TRAINER'S MANUAL

ADDICTION COUNSELLING TRAINING MANUAL

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Design and Production:
APH (MICOT) Canada Inc.

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ACKNOWLEDGEMENTS

PREFACE

This resource is the result of a project undertaken by the National Planning Committee (NPC), a working group of the Subcommittee on Alcohol and Other Drug Problems in Canada, to enhance knowledge and skills in the addictions counselling field. By 1980, this group had already spearheaded successful projects for training trainers and teaching basic knowledge in the addictions area. Working again through the NPC and its "national training system" framework, this group identified a substantial priority for "counselling skills training" across Canada.

Although there were numerous training programs, courses, and efforts existing in the various jurisdictions, there was an identified need to bring these resources together into a "state-of-the-art" curriculum which would serve as a baseline for training counsellors.

A Canada-wide needs assessment indicated that treatment related programs were often too long, too abstract, too advanced, not practical enough, not written down and too inflexible for front line trainers.

The Addiction Counselling Training (ACT) package is a modularized set of training materials drawn from contemporary sources in the field. It addresses the need for basic, brief training of workers new to counselling the drug dependent person.

The package consists of manuals for both trainers and participants. It is designed to be part of a larger training strategy, and can be easily modified or supplemented in order to meet more specific trainee requirements. Primarily, it attempts to address basic (i.e., fundamentally important) skills and knowledge which have broad relevance to many work settings.

The goal of this package is to enable addiction counsellors in the National Training System:

1) to receive a relevant, consistent, and comprehensive form of introductory-level or review training;

2) to be motivated to continue their training;

3) to achieve a clear, practical, basic foundation of knowledge, skills, attitudes, and continued learning tools.

The package is based upon a learning model which assumes that specialized knowledge and skills are best learned in a sequence in which more specialized, complex learning builds upon basic skills and knowledge.

The purpose of this material is *not* to suffice as counsellor training in and of itself, but rather to serve as a resource for training addiction workers who require some or all of this specialized knowledge and skill instruction. The package assumes no prior training in addiction counselling. It is modularized in such a way that it can be used totally or in part depending upon:

1) participants' backgrounds (prior training);

2) locally specific knowledge/skill requirements.

The beginning worker with less than one year of experience and no formal training is the primary target; however, the materials are also of potential use as refresher training for more experienced workers.

The package is made up of selected existing resource materials. Some are quoted, others are slightly edited, and others are summarized. Materials produced by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA)

have been updated and directly quoted without line by line referencing in some specific passages. This liberty was taken within the spirit of their policy on the materials being "public domain". All other citations are made as specifically as possible.

The ACT package is intended to be part of a more extensive training program. No pretense is made, nor is it assumed, that the completion of this program is sufficient for training counsellors.

The knowledge and skills training objectives of this package focus on pre-treatment counselling activities: that is, up to, and including, treatment planning activities, but not including specialized treatment.

There is an acknowledged emphasis on the more popularly used drugs (alcohol, barbiturates, antianxiety tranquillizers, and cannabis). As well, knowledge concerning risks and hazards of using specific drugs is uneven. Consequently, this unevenness is reflected in the content.

Extensive attempts have been made to ensure that the material included is up-to-date and accurate. With changing knowledge, this objective is elusive. However, the strategy being recommended is that users of the package continuously monitor and update the technical content. Thus, this manual and those that follow it should always be considered working documents. This leads to one final comment.

There is no substitute for a creative and experienced trainer. This said, however, training aids can assist in making program planning and delivery more efficient. The materials in this manual have been found useful in coping with the demands of variable target group needs and continuous staff turnover/retraining requirements.

INTRODUCTION – TRAINER'S MANUAL
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LIST OF FIGURES

INTRODUCTION TO THE ACT PACKAGE

Why the ACT Package?

In reviewing counselling training materials available, two extremes were observed:

1. Long, time-consuming packages which could not be used due to time constraints (not enough time for training).

2. Training materials which were very minimally documented (often existing in resource persons' heads).

The net result was that counsellor personnel were often not well prepared. This package presents fundamentals of interpersonal skills, drug information, interviewing, and individualized intervention planning to help trainers overcome time constraints.

What is the ACT Package?

This package consists of two sets of materials:

1. A Trainer's Manual, which consists of:

    – trainer's instructions,

    – training goal/objectives,

    – training materials (notes, exercises, activities).

2. A Participant's Manual, which consists of:

    – participant's readings and references.

The materials are organized in a modularized fashion, so that they can be used flexibly, according to particular participant group training needs. The four Units present interlocking topic areas, and each Unit is divided into modules or sub-topic areas.

These materials can be drawn upon to meet varying "competency" or "learning" needs, within whatever time is available. Thus, one or more modules from one or more Units can be organized and presented in one large "block" of time, or spaced out over several days/weeks (e.g., one hour per day or one day per week, etc.). At the end of this Introduction Unit, there is a planning sheet (Appendix B) which can be used to facilitate selection and organization of relevant Units and modules. These may be supplemented and/or altered.

Participants should all get a copy of the Participant's Manual, as a training reference, job aid and continued training resource.

Who should use the ACT Package?

Again, two answers apply:

1. The trainer or trainers should be experienced both in teaching the module content for which they are responsible and in practising as clinicians/counsellors.

    Thus, to deliver the total package, normally more than one trainer would be used. This is because both their credibility as a source of information and their ability to relate the material to fresh case examples are important factors in effective delivery.

2. Participants should be relatively inexperienced and/or untrained persons who perform direct or indirect counselling functions to substance abusers. It is important that the participants accepted, and the modules selected for delivery, be compatibly matched according to content and level of training. This match requires that the participants be clear ahead of time what the training will consist of, and

that the trainers carefully determine ahead of time what training is needed. This participant selection can be done through correspondence, discussion, telephone, one-to-one interview, or some combination of these. See INTRODUCTION UNIT, module 4 regarding training needs assessment. Rule of thumb: select Units/modules which are needed by participants to help them do their work. Adjust time of training to participant's level of skill.

How should the ACT Package be used?

Important considerations on how to use the materials are: how many participants; how many sessions, and how long should sessions be; how should sessions be ordered in sequence; how much and what space is required. Experience suggests the following:

– Six to eight participants per trainer and per room available appears to be the best "fit". This number allows for adequate small and large group discussion time;

– twenty-one total participants appears to be the maximum effective group size;

– four 1.5-hour sessions or six one-hour sessions with brief breaks (as needed) for a total of six training hours appears to be the effective limit for each training day;

– the ideal sequence appears to move from more generic skills and knowledge to more specialized skills and knowledge (approximately as they are presented in the package;

– the space used should ideally provide for a quiet, comfortable, and private room large enough for the total group and a sufficient number of similar but smaller discussion rooms to accommodate each small group of six to eight participants;

– all rooms should ideally be equipped with blackboards and/or flipcharts, along with suitable chalk/markers;

– videotape equipment, slide projector, and overhead projector are optional equipment in the larger room;

– participants should all have Participant's Manuals, either ahead of time or distributed at suitable intervals, depending on the training plan.

Scope and Limits of the ACT Package

It is possible to view this package as either too much material or not enough material on the subjects covered. The judgment depends almost entirely on the baseline knowledge/skills of the participant group and the amount of time available for delivering the training. The need and priority for training should determine whether and how these materials are used.

The package does not purport or attempt to go beyond basic (i.e., fundamentally important) knowledge and skills for assessment, treatment planning and case management functions of counselling. It assumes that continued training will be necessary.

Trainers might be well advised to be selective regarding how and which materials are presented. The participant handbook can serve as both a reference and a self-learning tool in this respect. Also, see Appendix A for "Training Considerations".

Goals and Objectives

To the extent possible, each session relates to specific instructional goals and objectives. These are stated at the beginning of each Unit and module. The following areas are covered:

- The first Unit (Counselling Communication Skills) focuses on practising interpersonal skills which are needed to establish and maintain a positive relationship as well as to deliver counselling interventions effectively;

- the second Unit (Practical Drug Concepts) is directed at enabling counsellors to know what and how drugs affect users, in terms of major hazards and indicators to estimate risks;

- the third Unit (Initial Interview Methods) provides guidelines and practice for assessment interviewing. It combines counselling skills and practical drug concepts around methods of exploring, analysing, and organizing client information for treatment planning;

- the fourth Unit (Treatment Planning Strategies) describes principles, approaches, and tools for understanding individual patterns of substance abuse for purposes of treatment planning and case management. Specialized treatment approaches are referred to, but not covered;

- module four of this (Introduction) Unit, on training needs, provides an opportunity and structure for specifying what present and further training is required for those who participate in the program.

Figure 1 outlines the Units and modules covered.

SEE APPENDICES A – G FOR GUIDELINES TO PLANNING A SPECIFIC PROGRAM FOR A SPECIFIC TARGET GROUP.

Introductory Perspective

Each Unit is preceded by a brief "Introductory Perspective", which summarizes the major purposes, limitations, and advantages known about the material covered by the Unit. This material should assist the trainer to judge with relative ease whether the Unit is suitable or adaptable to a particular group's requirements.

The Overview section in the following pages should be consulted and used to orient participants:

1) to each other;

2) to the goals and content of the program;

3) to the training activities/methods;

4) to training needs assessment.

Ideally, this first session should be one in which participants become comfortable working with each other in the context of appropriate expectations.

It is important to note that the sample schedule times provided in each Unit assume a great deal of pre-course preparation work by participants, as well as trainers. In actual practice, all participants/groups will be somewhat unique. Thus no "standard" training timetables can be projected in advance.

A good "rule of thumb" is to assess participant skill/knowledge ahead of time and stay with a particular learning activity/area until it is mastered.

Needs Assessment

The comments above clearly stress the importance of needs assessment. Is training needed? If so, what tasks need improvement? Which of these can be assisted by training?

Witkin (1984) points out that ". . . . there are several cogent reasons why needs assessment is more important and more useful than ever"!

1) Reduction in resources;

2) increased competition for funds;

3) opportunity for improved service delivery through need analysis;

4) responsiveness to changing societal needs;

5) reconsideration of organizational goals.

Any one or more of the above can have important impacts on training needs. Ideally, prior to conducting this (or any) training program, program administrators should conduct some form of needs assessment (considering: purpose; target group; users; existing estimates; outcomes; time-frames; resources available).

Appendices A – F of this Introduction Unit are designed to assist in conducting needs assessment, and planning prior to training.

ADDICTION COUNSELLING TRAINING PACKAGE CONTENT
Figure 1

	UNITS			
	I	II	III	IV
MODULES	COUNSELLING COMMUNICATION SKILLS	PRACTICAL DRUG CONCEPTS	INITIAL INTERVIEW METHODS	TREATMENT PLANNING STRATEGIES
1	ORIENTATION	DRUGS	ASSESSMENT	FUNCTIONAL ANALYSIS
2	REFLECTIVE SKILLS	HAZARDS	THE INTERVIEW	MAJOR MODALITIES
3	DIRECTIVE SKILLS	RISK INDICATORS	SIMULATION	MATCHING
4	OBSERVATIONS AND CONCLUSIONS	CASE APPLICATIONS	ASSESSMENT DOCUMENTATION	CONTINUED CARE/ MANAGEMENT

OBJECTIVES
INTRODUCTION

MODULE 1: RATIONALE

Goals/Objectives

The goal of this module is to help participants get to know each other and understand what problem is being addressed by the ACT strategy and curriculum.

At the end of this module participants should know each other's first names and be able to explain the major reasons for developing the ACT strategy and curriculum materials, as they relate to their own training needs.

MODULE 2: OBJECTIVES

Goals/Objectives

The goal of this module is to ensure that participants receive clear information as to the intended outcomes of the overall training program.

By the end of this module participants should be able to demonstrate a clear perception and understanding of the curriculum objectives.

MODULE 3: CONTENT

Goals/Objectives

The goal of this module is to preview the course material.

By the end of this module, participants will be able to identify the key content areas covered by the curriculum.

MODULE 4: TRAINING NEEDS PROFILE

Goals/Objectives

The goal of this module is to provide for a review/profile of participant training needs in counselling substance misusers.

By the end of this module participants should have designed a personal competency profile and described a plan for achieving desired improvements.

SAMPLE SCHEDULE

(Assuming it is conducted the evening before Unit I)

SAMPLE TIMES	TIME REQUIRED	TITLE	ACTIVITY/ FORMAT	MATERIALS	PAGE
4:00	5 min.	**Module 1** Rationale	Activity A – Outline of Course	(Trainer's and Participant's Manuals only)	3 and 4
	30 min.		Activity B – Get Acquainted		5 and 6
	25 min.	**Module 2** Objectives	Activity A – Overview	– Overhead Projector – Transparencies outlining objectives	9 and 10
	10 min.	**Module 3** Content	Activity A – Units and modules	– Overhead Projector – Transparencies Objectives	13 to 27
	15 min.		Activity B – Assumptions	(Trainer's and Participant's Manuals only)	29 to 31
	15 min.	**Module 4** Training Needs	Activity A – Competency Profile	– Training Needs Assessment Checklist (Appendix F)	35 and 36
	20 min.		Activity B – Development Plan		36 and 37
		BREAK (Refresh-ments/ Sociali-zation			

Module 1: RATIONALE

- **Rationale**
- **Objectives**
- **Content**
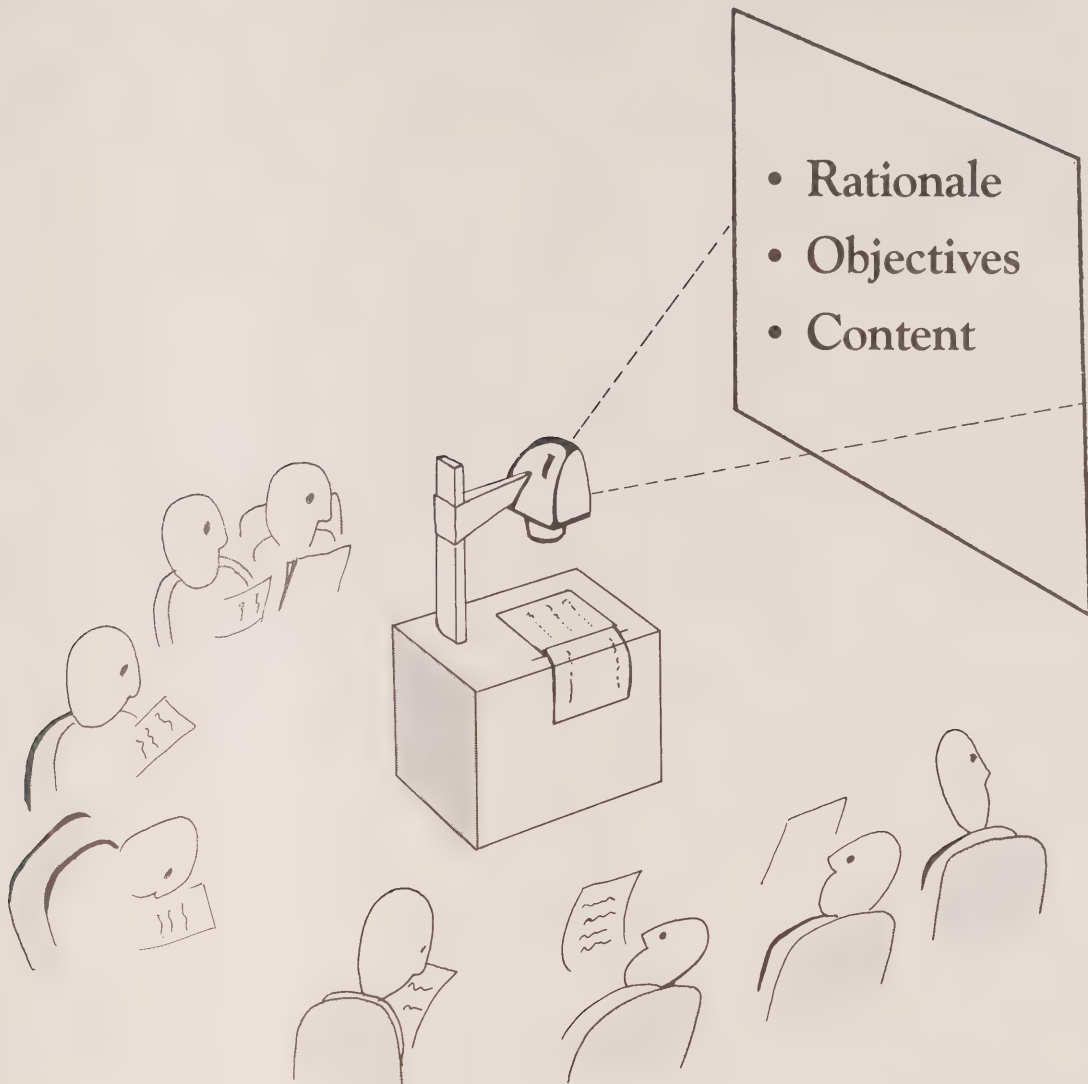
Module 1: RATIONALE

OVERVIEW OF MODULE 1: RATIONALE

Time required	35 minutes
Format	Large group – lecturette – exercise – discussion
Supportive materials	– Trainer's/Participant's Manuals
Learning objectives	Ensure that participants: 1) have accurate/appropriate expectations; 2) establish an atmosphere conducive to group learning.
Trainer qualifications	The trainer should: 1) have conducted and/or practised the conduct of this program previously; 2) have reviewed pertinent sections of the ACT material within the week prior.

ACTIVITY A

OUTLINE OF COURSE

Time required	5 minutes
Format	Large group briefing
Supportive materials	– Participant's Manuals – flipchart/blackboard – felt pens/chalk
Learning objectives	By the end of this module, participants should be able to describe what to expect during the next two hours.

Instructions For Training Activity A

Begin by introducing the following:

Key Points

1) Emphasize the importance of "basic" (most important) knowledge/skills, in relation to the ACT program.

2) Clearly acknowledge the limits as to what can be accomplished in a short program such as this, unless it is within a larger program (see Figure 2, page 15).

3) Refer to Module 4 – TRAINING NEEDS, and stress how essential follow-up is to brief training such as this.

   Note that careful screening of participants helps to ensure that they will benefit from this program.

4) Outline the content of the remainder of the module:

   – get acquainted exercise (to enable them to maximize their peer learning exchanges);

   – review of objectives (to clarify expectations);

   A) To achieve a basic foundation of knowledge, skills and attitudes needed for counselling substance misusers;

   B) To be motivated to continue this training.

   – review of the training contents and processes used (to clarify the training model and sequences).

   A) Presentation

   B) Practice

   C) Discussion and feedback

5) Answer any questions.

ACTIVITY B

GET ACQUAINTED

Time required   30 minutes

Format   Large group exercise.

Supportive materials
- Trainer's Manual
- moveable chairs

Learning objectives   To facilitate interaction among participants, so that they will be able to:

1) identify the interests and "resources" of others in the group;

2) ask questions and make comments freely.

Note: This exercise can be deleted if the above conditions already exist. However, do not assume they exist. Find out through consulting with participants.

Instructions For Training Activity B

Begin by saying that "before we get into knowledge and skills, we should get to know each other".

Exercise Instructions

Arrange the room so that there is one chair for each participant. Next, arrange the chairs in two concentric circles with four to six chairs in each, placed facing each other. (NOTE: If there is an even number of participants and workshop leaders, the exercise leader will not be a participant; however, if the number of participants and resource persons is uneven, the exercise leader may also participate in order to ensure that each circle has the same number of members).

Ask participants to choose a seat. Once seated, everyone should be facing one other person and there should be an inner and outer circle.

The exercise involves a series of instructions – the first of which is:

a)   You are your "dream" house – describe yourself and your setting – you have 30 seconds. Begin with the persons in the inner circle talking to the persons facing them in the outer circle. The person listening DOES NOT RESPOND! After 45 sec-

onds, ask the persons in the outer circle to describe the type of house they are and their setting. Again, only listening – no interaction! Once both have finished, the outer circle moves one chair to the left.

The instructions remain the same for (b), (c), (d), and (e).[1]

b)   You are your favourite vehicle – describe yourself.

c)   You have won a free trip to anywhere – where?

d)   You have won $25,000 and must spend it all in two weeks. How?

e)   You have won a scholarship and are going to accept it – what would you like to take as further or new education?

At this point, allow participants 60 seconds to respond to (f), (g) and (h).

f)   You have become independently wealthy – how would you choose to spend the rest of your life?

g)   You have been given a promotion – to your ideal job. Describe it.

h)   You may return to any age in your life – what age would you choose to return to and why?

At this point, participants may wish to talk longer than 60 seconds and allow the listener to respond.

i)   You may change anything about your life – what and why?

j)   You may change any Canadian social problem – what and why?

k)   You may change any international social problem – what and why?

l)   What is your major question about drug use issues?

m)   Why are you here today?

n)   What would you rather be doing?

o)   What questions do you have about me (the person sitting opposite to you)?

For questions (i), (j), (k), (l), (m), (n) and (o), you may wish to have participants rotate and ask the same question over again to a different person. This can be varied as the time and circumstance warrant. Eventually, this exercise breaks down into dyads or small groups talking. Ideally, it could be followed by a 10-15 minute coffee break.

Leaders are encouraged to try variations on the theme – combining the people facing each other into groups of 4, 6, and 8 developing their own instructions, etc.

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[1] Trainers may wish to include, add or delete particular items in the list.

Module 2: OBJECTIVES
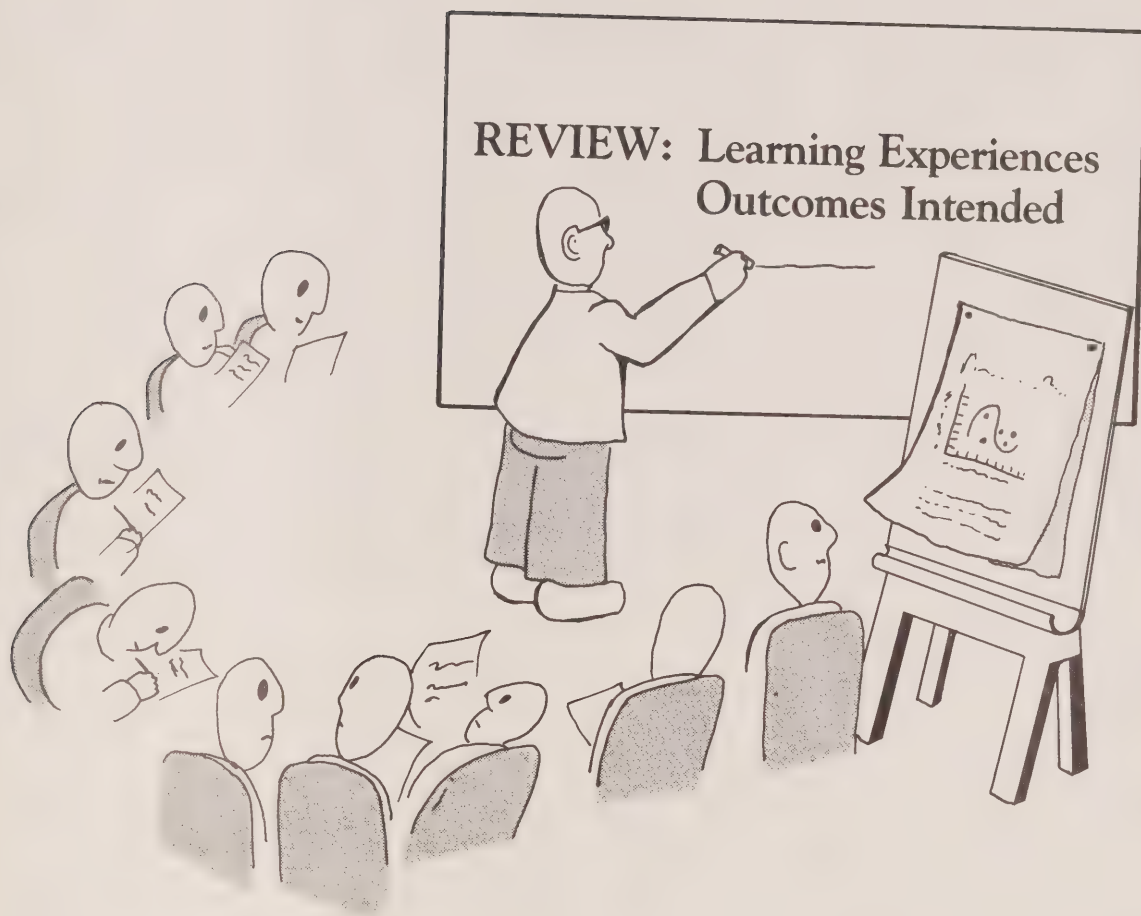
Module 2: OBJECTIVES

OVERVIEW OF MODULE 2: OBJECTIVES

Time required   25 minutes

Format   Large group
   – lecturette
   – discussion

Supportive materials
   – Flipchart/blackboard
   – felt pens/chalk
   – Participant's Manuals (For the remainder of this
      program, it is assumed that Participant's Manuals
      will be needed)
   – overhead projector (optional)

Learning objectives   Ensure that participants:

1) can generally describe the intended outcomes of
   the program;

2) can identify objectives that are most important
   to them as individuals

Trainer qualifications   The trainer should:

1) have conducted and/or practised the conduct of
   this program previously;

2) have reviewed pertinent sections of the ACT
   material within the week prior.

ACTIVITY A

OVERVIEW

Time required   25 minutes

Format   Large group.

Supportive materials
   – Flipcharts/blackboard
   – overhead projector (optional)
   – felt pens/chalk

Learning objectives   By the end of this training activity participants
   should indicate through discussion that:

1) the objectives of the program are suited to their
   "training needs", i.e., the training will help them
   complete tasks that they have to perform in their
   work;

2) they are ready to proceed.

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Instructions For Training Activity A

Begin by presenting the following:

Key Points

1) Restate overall goals:

   - deliver consistent, relevant, and comprehensive training;

   - motivate continued training;

   - attain practical, basic knowledge and skills.

2) State overall objectives:

   - increase ability to apply basic counselling skills and practise drug use concepts in simulated assessment interviews for treatment planning;

   - continue to assess participants' training needs;

   - enable participants to conduct accurate assessments and suitable referrals.

3) Using flipchart and/or overhead projector, briefly (using specific objectives from each module to be covered) sketch out and explain the intended learning outcomes for the day.

   Note: This should be done at the beginning of each training day. These may be taped on the wall and referred to as training proceeds.

4) Ask if there are questions regarding the specific module objectives stated in the manual.

Module 3: CONTENT
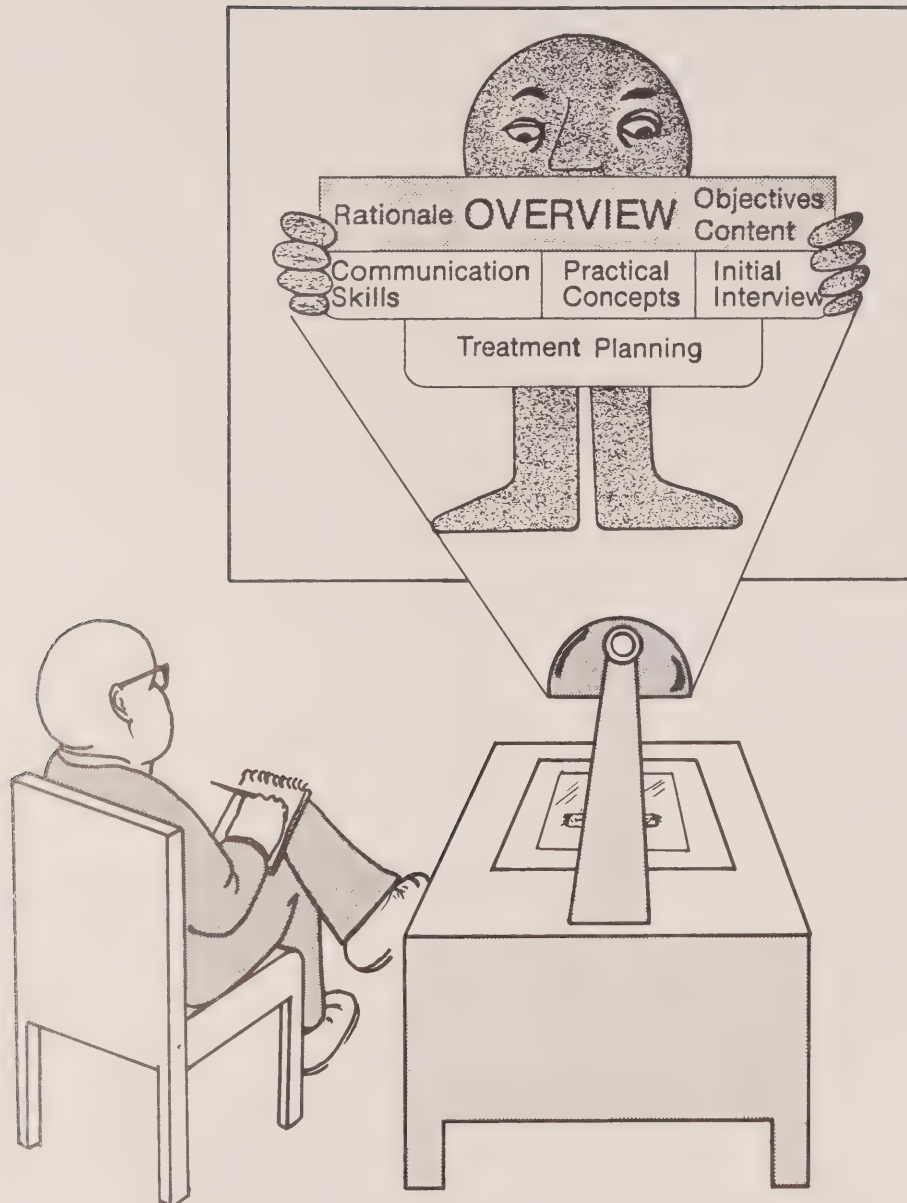
Module 3: CONTENT

OVERVIEW OF MODULE 3: CONTENT

Time required	25 minutes
Format	Large group – lecturette – discussion
Supportive materials	– Overhead projector – transparencies of Figures 2 to 8 (or those Units being used)
Learning objectives	Ensure that participants: 1) can identify the topic titles being addressed in the program; 2) discuss the major contents and assumptions behind this training program.

ACTIVITY A

UNITS AND MODULES

Time required	10 minutes (will vary according to the number of modules used)
Format	Large group.
Supportive materials	– Overhead projector – transparencies 2 – 8
Learning objectives	The purpose of this session is to brief participants on the major content areas and familiarize them with the training resources, model, and sequence to be used. By the end of this training activity participants should be able to: 1) describe the training model (units, modules, training activities and sequences); 2) discuss the assumptions underlying the ACT program in such a way as to indicate their suitability as participants.

Instructions For Training Activity A

1) Begin by using selected transparencies of Figures 2 – 8 to highlight content areas. Invite questions during this process. Stress the importance of the "context" of this program (Figure 2, page 15).

2) Describe and explain the overall training sequence which is used when possible:

   – exercise used to highlight the relevance of the concept/skill;

   – brief lecture to emphasize key points;

   – discussion and/or practice exercises;

   – "homework" in Participant's Manual (e.g., assigned readings);

   – integration exercises to connect various Units/ modules.

FIGURE 2

Ongoing Training Needs Assessment

Training of Trainers

Immediate Response Program

Modularized Training Program

Continued Education

FIGURE 3

OVERVIEW

Rationale

Objectives
Content

Communication
Skills

Practical
Concepts

Initial
Interview
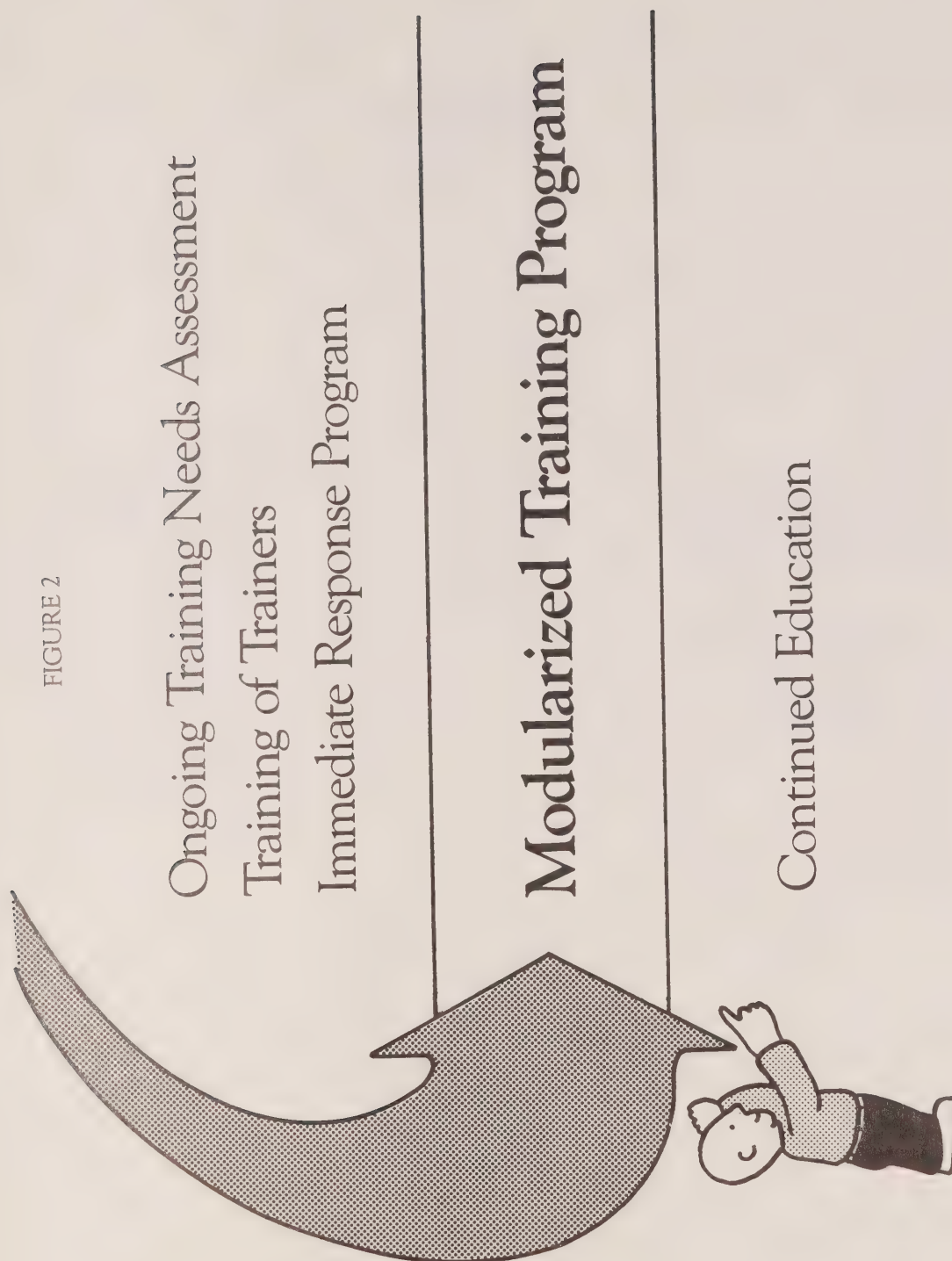
Treatment Planning
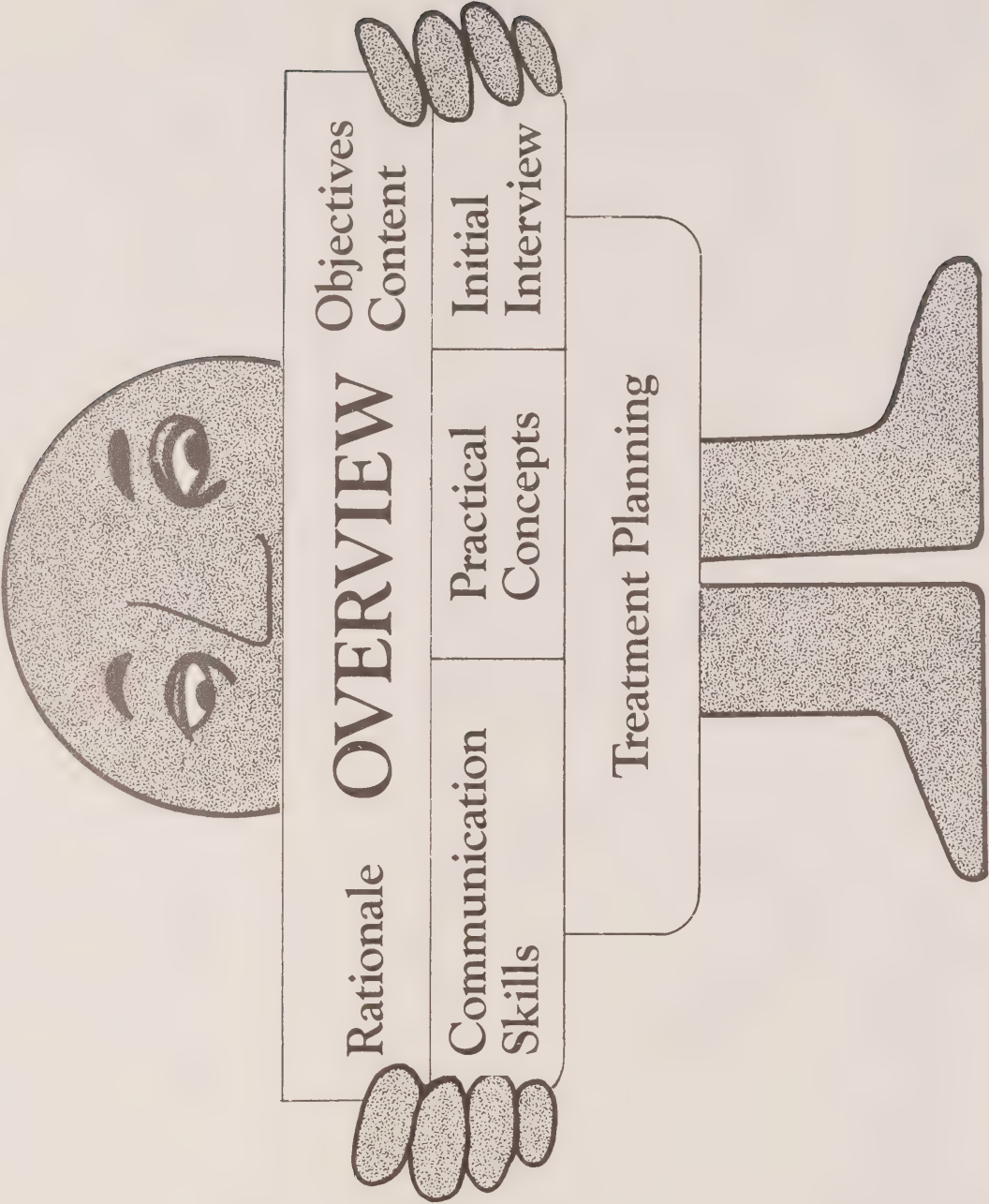
FIGURE 4

Communication Skills	Practical Concepts	Initial Interview
Treatment Planning		

Communication Skills

- Orientation

- Reflective Skills

- Directive Skills

FIGURE 5

Risk Indicators

Hazards

Drugs

| Communication Skills | Practical Concepts | Initial Interview |
| Treatment Planning | | |

PRACTICAL CONCEPTS

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FIGURE 6

Communication Skills	Practical Concepts	Initial Interview
Treatment Planning		

INITIAL INTERVIEW

Interview

Simulation

Assessment

Assessment Documentation

FIGURE 7

TREATMENT PLANNING

Functional Analysis

Major Modalities

Matching

Continued Care Management

Communication Skills	Practical Concepts	Initial Interview
	Treatment Planning	

FIGURE 8

Training Needs

- Competency Profile

- Development Plan

Communication Skills | Practical Concepts | Initial Interview

Treatment Planning

ACTIVITY B

ASSUMPTIONS

Time required	15 minutes
Format	Large group
Supportive materials	– Flipchart/blackboard – overhead projector (optional) – felt pens/chalk
Learning objectives	By the end of this training activity, participants will be able to explain:

1) the practical considerations (training time, work force qualifications, turnover) which led to developing these materials;

2) the assumptions behind the structure and sequence of this training.

Instructions For Training Activity B

Begin by commenting on the background of these materials.

Prior to development of this package, discussions, consultations and structured needs assessment processes were conducted across Canada. These inquiries led to some general consensus about the kinds of training materials which appeared relevant.

Practical Considerations

The day-to-day operations of treatment programs bring about important limitations on how, when and where training takes place:

1) time available for training is limited;

2) lead time for planning is often short as well;

3) many treatment-related jobs depend on hiring personnel who have not had basic addictions training, or whose prior training was not sufficient to perform practical tasks required.

These observations led to the assumption that there was a need for training materials/programs which were:

– brief;

– basic;

– modularized for flexible application.

Theory and Content Considerations

In considering what knowledge and skills were potentially most important, Chaudron, Bohm, and Sharma (1982) developed a knowledge and skill categorization framework for training counsellors. Based on the collective experience of trainers in a treatment training centre, this framework stressed the importance of:

1) making training as experiential and practical as possible in relation to counselling tasks;

2) timing the training, to the extent possible, to coincide with learner "need", and providing it in a sequential, cumulative process moving:

    — from basic to specialized;

    — from simple to complex;

    — from simulated to real cases.

3) grouping knowledge and skills into four interlocking areas of pre-treatment training activity:[2]

    — Counselling Communication Skills;

    — Practical Drug Concepts;

    — Initial Interview Methods;

    — Treatment Planning Strategies. (See Figure 9, using overhead projector or flipchart or Participant's Manual).

4) referring to Figure 1, which gives a further breakdown of:

    — all four UNITS; and

    — all 16 modules (4 × 4)

5) answering any questions.

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[2] "Pre-treatment" refers to knowledge and skills required for counselling activities up through treatment planning but not including specialized treatment.

FIGURE 9

ACT PACKAGE
INTERLOCKING CONTENT
GENERIC TRAINING

Practical
Drug
Concepts

Initial
Interview
Methods

Treatment
Planning
Strategies

Counselling
Communication
Skills
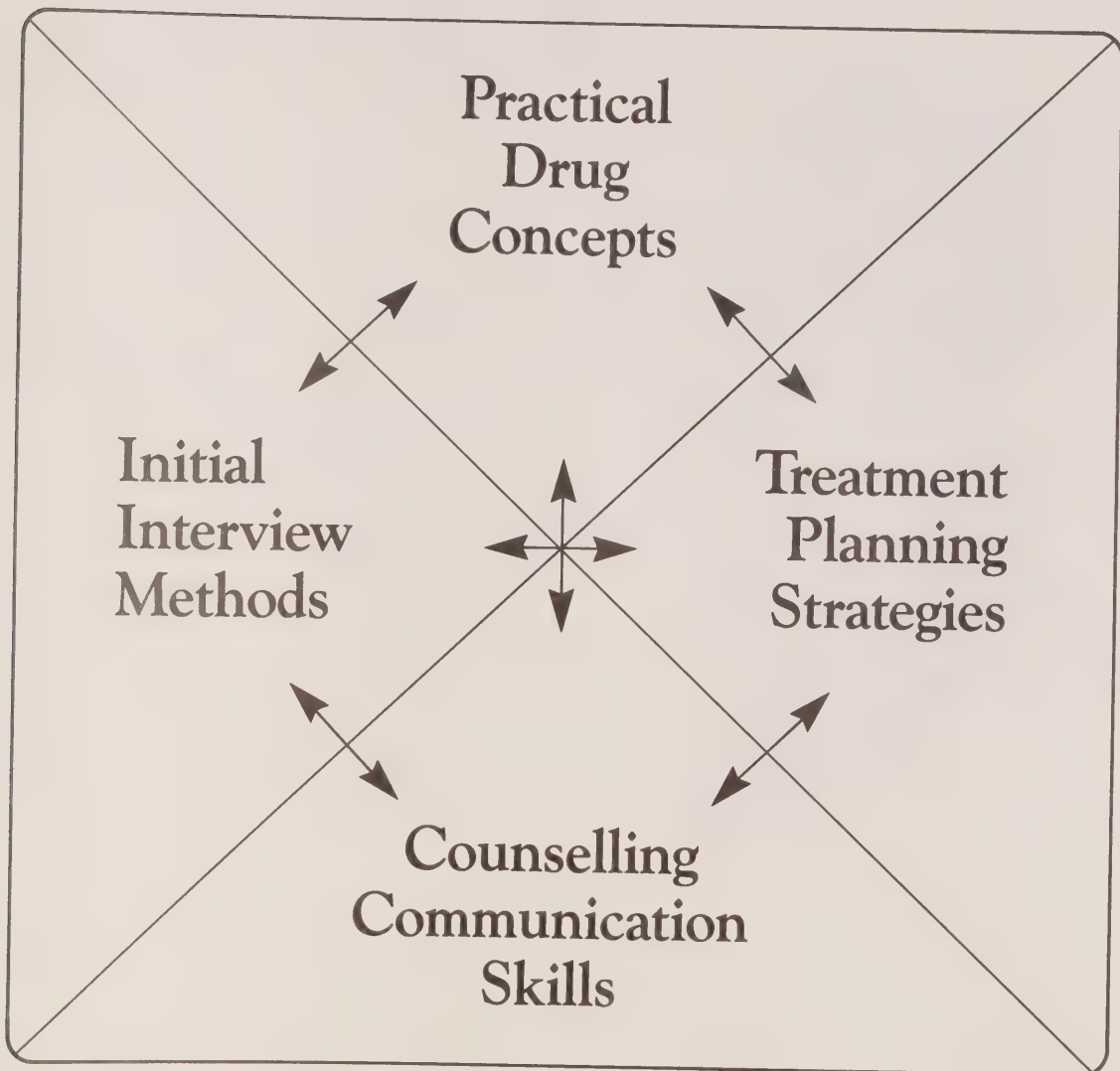
Module 4: TRAINING NEEDS PROFILE
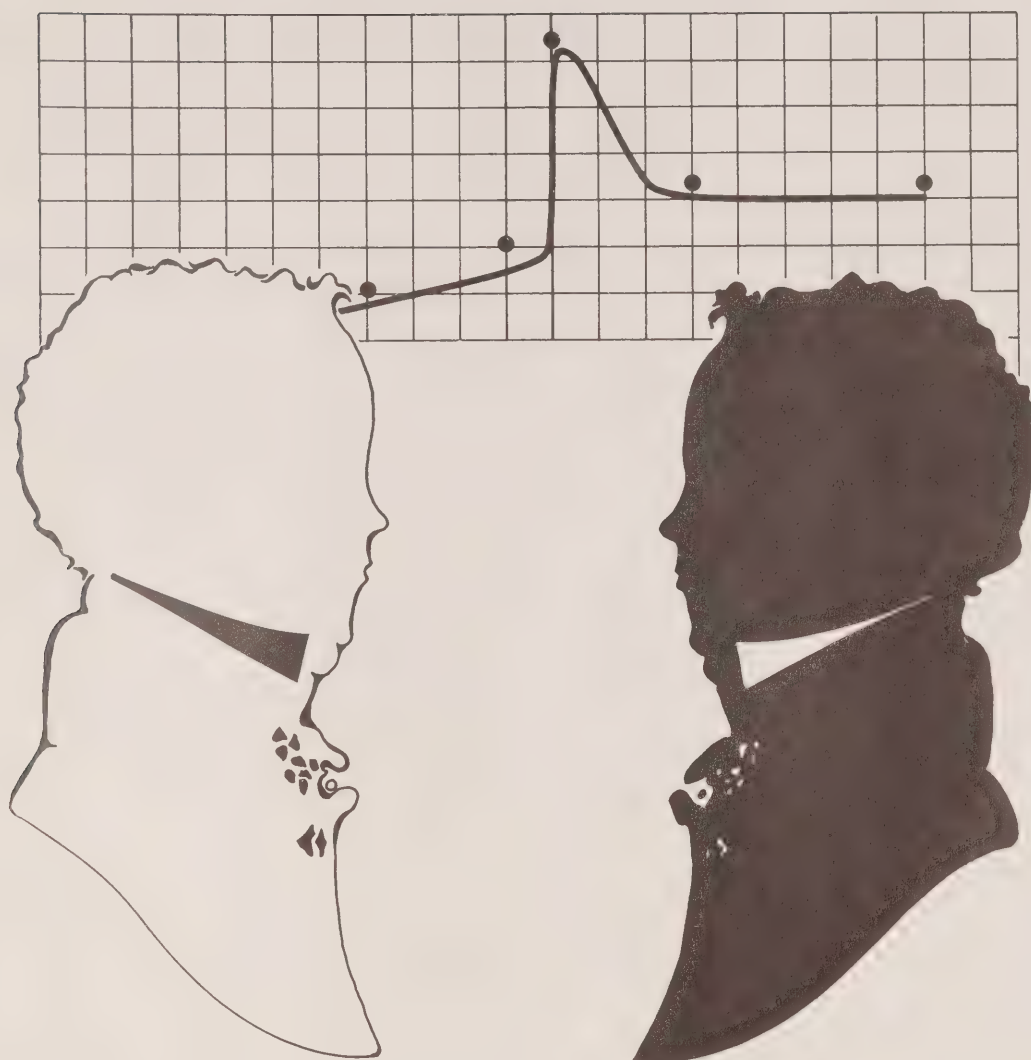
Module 4: TRAINING NEEDS

OVERVIEW OF MODULE 4: TRAINING NEEDS

Time required	35 minutes (assuming considerable needs assessment has already been done with participant group prior to this training)
Format	Large Group – individual exercise – lecturette – discussion
Supportive materials	– Training Needs Assessment Checklist (page 18 in Participant's Manual)
Learning objectives	Ensure that participants can: 1) define "training needs" generally; 2) profile their training needs; 3) initiate a plan for continued training.
Trainer qualifications	The trainer should: 1) have conducted and/or practised the conduct of this program previously; 2) have reviewed pertinent sections of the ACT material within the week prior.

ACTIVITY A

COMPETENCY PROFILE

Time required	15 minutes
Format	Large group – individual – discussion
Supportive materials	– Training Needs Assessment Checklist (page 18 in Participant's Manual)
Learning objectives	By the end of this learning activity participants will have specified: 1) skills and knowledge in which they feel strongest; 2) skills and knowledge they feel need the most improvement (training).

Instructions For Training Activity A

Note: The trainer should have considered guidelines in APPEN-
DICES A-F of this Unit in planning the program to this point.

Begin by noting that because Units I to IV are designed to be
a "basic minimum" exposure to fundamentals of counselling drug-
dependent clients, the need for continued training is assumed. This
falls into two major categories:

1) further review and practice of the fundamentals covered.
This need can apply to experienced as well as beginning
counsellors, because it is easy to lose sight of the basics
and new knowledge is continuously being generated;

2) more specialized and/or advanced training in some
aspect of treatment service delivery.

The long-term value of the training will, in large measure, be
determined by the efforts made by participants to assess their
competence and plan for relevant follow-up learning.

Focus of this Unit is:

1) what knowledge and skills exist (before the training)?

2) how well has each participant learned the material? How
can the learning be reinforced? What further training is
needed to perform job functions (after training)?

Ask participants to fill in their Training Needs Assessment
Checklist pages 18 to 21. (Answer questions as necessary.)

Indicate that they will fill out the checklist again at the end
of their training; so that they can monitor their progress.

ACTIVITY B

DEVELOPMENT PLAN

Time required	20 minutes
Format	Large group
Supportive materials	– Training Needs Assessment Checklist (pages 18 to 21 in Participant's Manual)
Learning objectives	By the end of this activity, participants will have prioritized their training needs on their Training Needs Assessment Checklist.

Begin by asking if there are any more questions about filling out the Training Needs Assessment Checklist.

After answering questions, instruct participants to:

1) circle each item scored as "needs improvement";

2) review these items on the list;

3) rank each of these items in order of "need to improve";

4) "go ahead", with the understanding that the process is imperfect, but will give them a basis for estimating (at the end of the program):

   a) how much they learned;

   b) what further training needs exist.

Finally, call participants' attention to the feedback form (Appendix G in Trainer's Manual) which will be used to evaluate the delivery process for each Unit.

Answer any final questions.

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APPENDIX A

TRAINING CONSIDERATIONS AND TECHNIQUES[3]

The ultimate success of any training program, regardless of how carefully designed, is related to the trainer's skill in delivery. For that reason, this appendix presents a brief review of some training know-how needed to maximize the effectiveness of these materials.

Topics include:

- The Adult Trainee;
- The Trainer's Role;
- Serving on a Training Team;
- Groups and How They Behave;
- Training Methods;
- Use of Audiovisual Media.

This information represents the wisdom of experienced trainers who have presented these training materials and participated in countless other training programs. It can provide a useful, quick review for those already experienced in group leadership, and it can serve as helpful refresher material for those whose skills might be rusty.

The Adult Trainee

Adults who attend training programs are usually seeking very specific, job-related skills or knowledge. In general, trainees are:

- independent;
- experienced;
- problem-centered; and
- "now" oriented.

Thus, trainees have to feel that the learning is relevant to their needs before they are willing to accept it. For this reason, effective training has to be:

- self-directed (the learner is involved in conducting the learning experience);
- experienced-based (learning activities are planned around the participant's experiences);
- problem-centered (learning centres on learner's needs and problems, not on "covering" subject); and
- immediate in application (learning can be put directly into action).

This training package is designed to provide participatory learning experiences through which trainees relate new information to their experiences and needs.

As the leader of adult learners, the trainer is responsible for creating the kind of open learning environment that enables trainees to share their experiences and individual expertise with other participants.

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[3] National Institute on Alcohol Abuse and Alcoholism (1979).

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The Trainer's Role

Trainers use a number of different, and sometimes highly individualistic, approaches to conducting training sessions and meeting the needs of the adult learner. As a general rule, however, skilled trainers start by putting participants at ease. Drawing people out during the first session with questions about themselves and their expectations for the course allows trainees to get to know each other and gives guidelines about their needs. This approach also encourages a sense of involvement among participants. The physical environment also helps set the atmosphere for involvement. Arranging the seating in a circle or around a large table is conducive to informal exchange among participants rather than exchanges only between participants and the discussion leader.

As a second task, experienced trainers usually set the group rules by beginning each session with a clear statement on the topic, the activities to be included, and the learning objectives. After information is presented, the trainer initiates discussion. If people are reluctant to speak first, the trainer often volunteers a comment, contributes information, or breaks the topic down into more specific questions.

The trainer sometimes must provide information to give the group some basis for learning and discussion. There are also times to seek information. This may require calling on participants with special knowledge or experience or bringing in an expert on the subject. Sometimes a participant can be asked to look up information and report it to the group.

Other trainer responsibilities include keeping the discussion on the subject and making sure the learning activities stay on schedule. A brief summary after each learning activity and at the end of a session serves as a logical conclusion to the activity and also gives trainees a road map to follow as they sort out where they are going and where they have been. In carrying out these tasks, it is important for a trainer to:

–   avoid seeming to pass judgment;

–   make positive comments and give positive feedback;

–   be aware of and candid about personal biases;

–   avoid pretending to be an authority on subjects he or she doesn't know thoroughly, and

–   be frank about his or her personal style of group leadership.

Serving on a Training Team

Often more than one person will be involved in the presentation of a training event. The use of a team is particularly advisable if the training program extends to more than one day, or if the content is complex and technically demanding. The same principles apply regardless of how many people serve in the role of trainer, but a few special precautions need to be observed for team efforts.

First, there needs to be a clear-cut delineation of who delivers what materials and exactly how much content the individual presentations will encompass. Redundancy and a lack of coordination in the subject matter are likely without this assignment of responsibilities. If possible, team members who are not "performing" should still be observing. The trainer who has not attended sessions other than his or her own presentations may encroach upon areas that have already been covered by others or miss points brought up earlier that could integrate the learning experience or add emphasis. Periodic debriefings for team members assist in coordination if it isn't practical for the whole team to be present for each session.

Groups and How They Behave

One of the "tricks" to being an effective trainer lies in understanding how groups work. The successful trainer knows what forces make people and groups act as they do, and uses these dynamics to help guide the learning experience.

Two major factors shape the behaviour of most groups. First, participants have to decide, "Do I really want to learn *this* from *you?*" As they make this decision, participants tend to "test" the trainer to decide whether they can accept his or her leadership. Sometimes acceptance is achieved shortly after the start of a session; at other times it may take longer. Another aspect of acceptance requires that the trainees decide to learn what is being presented. The participants have to analyse and, in a very real sense, agree to learn what the trainer offers. To guard against acceptance problems, the trainer should:

- be thoroughly prepared for the presentation;

- make sure the logistics run smoothly;

- be frank about what he or she knows or does not know;

- clarify participant expectations at the very beginning of the training program;

- compare these expectations with the training objectives, and

- discuss how unmet expectations can be handled.

If there is a problem, some tell-tale signs include:

- yawning or fidgeting;

- private conversations among participants;

- challenging or off-the-subject remarks, and

- questioning of the content validity.

When such problems arise, the trainer must deal with the issues openly to avoid bigger problems. He or she can:

- point out what is happening in terms of group processes;

- ask the group what can be done to satisfy their needs, and

- meet separately at a coffee break with discontented people and deal personally with their concerns.

The second dynamic which shapes group behaviour is the need for each individual to locate himself or herself within the structure of the group. This force is most obvious at the beginning of a training event when participants typically explore how to:

- establish themselves as important members of the group;

- guard their vulnerabilities, and

- get attention and recognition.

The need for group recognition and membership often leads to behaviour patterns that may interfere with learning. Trainers, therefore, need to be on the alert for the following "types":

- recognition seeker (constantly calls attention to himself or herself);

- conversationalist (brings up off-the-subject, and often personal, anecdotes);

- silent partner (sits quietly, daydreams, and does not participate);

- sophisticate (assumes bored, know-it-all attitude);

- moralizer (advocates judgmental points of view based on personal convictions);
- conservative (convinced that status quo does not need changing);
- aggressor (attacks other attendees rather than their ideas);
- theorizer (talks in abstract terms that often are unrelated to the discussion);
- fatalist (believes that nothing can be done about a problem);
- rationalist (believes only in logic and rejects emotional factors);
- thinker (appears to pay attention but does not participate).

Recognizing that these types of behaviour represent individual ways of coping with the strains of fitting into a group can help a trainer deal with them. Respectful, tactful treatment may integrate the problem individual with the group and neutralize the disruption. Keep in mind what underlies the behaviour and try to respond to that need. Thus, try slowly to draw out the silent person without making him or her more self-conscious; give some recognition to the types who try to dominate a discussion, but be sure that others have equal opportunities to participate.

To cut short an off-the-subject remark tactfully, ask those with an interest in the topic to get together at the next coffee break. Sometimes the group can help. For example, ask, "What shall we do about keeping on schedule when so many people want to discuss this issue?" The group members usually deal very effectively with the situation.

There is no simple technique for handling attention-seeking behaviour in groups. A good trainer approaches each individual as a new problem, keeping in mind a few general rules:

- deal in some way with the disruption; if not handled immediately, it will just appear again, often as a bigger problem;
- remember that you are the group leader and that challenges to that role should be met head on;
- keep in mind that your responsibility is to the whole group; no single individual should be allowed to disrupt the planned learning experiences.

Training Methods

To achieve its objectives, this training program uses an assortment of methods compatible with the basic principles of adult learning. The session-by-session information indicates when to use which method; the following pointers tell how to use them.

Discussion

Group discussion, one of the most frequently used techniques in training sessions, is generally initiated by the trainer's question or by information given in presentations, overhead transparencies, or reading material. The participants then contribute examples, observations, comments, and anecdotes from their own experiences in order to expand and illustrate some of the points made in the session. Some of the contributions provide striking, first-hand accounts from those who have dealt with different situations. Some comments and suggestions may be less useful than others, but the diversity will bring the subject to life and make the sessions personal and meaningful.

Discussion is not just a rambling, formless conversation that jumps from topic to topic, but is focused and directed to a specific issue or subject. The job of the trainer is to ensure that the discussion remains relevant and that rambling is minimized.

Personal experiences can be valuable contributions to discussions, but some participants may be tempted to use the discussion as a confessional.

Very difficult, emotionally charged situations that have little learning value can develop. Aim at achieving balanced participation from the group. Some people may want to "say their piece", but others in the group usually are not interested in such speeches unless they directly relate to the subject.

As a discussion leader, it pays to be aware of body language, both your own and that of the participants. For example, the trainer can use gestures to keep the flow of conversation going. Pointing to an individual who has something to say is perfectly polite in this context; so is a hand signal encouraging someone to elaborate. The direction of the trainer's attention itself is a powerful signal. As long as the leader is looking at someone, he or she will be encouraged to continue; looking away or at someone else may cut the flow of speech.

A trainer's ability to ask good questions is the most useful tool for bringing discussions to life and keeping them focused on relevant topics. A probing question arrests the attention and permits the trainees to be self-directed in finding an answer, to draw on their own experience, and to focus on an issue rather than an answer. Incisive questions also cast the trainer in the role of peer seeking answers, thus establishing a productive trainer-trainee relationship.

A few simple tips can help a trainer ask the kinds of questions that lead to fruitful and purposeful discussion:

- ask questions that start with "how" or "why" rather than "what is." These questions will encourage the development of the learners' analytical skills. Phrased this way, questions make learners apply what they know, and discover what they still need to find out;

- ask questions that spark controversy and force people to disagree. Such questions serve to broaden minds and dispel the illusion that everything is black or white;

- ask open-ended questions that have more than one right answer and are likely to elicit more than one response. For example, start with "In what ways....?" or "For what reasons....?" These kinds of questions foster a mind-set that is open to the nuances required to understand the complexity of most topics;

- don't put people on the spot with such questions as "What is the chemical formula for....?" or "Does anyone understand....?" An inability to answer the first questions or an honest "no" answer to the second would make someone feel stupid.

Simulations

Using a simulated community and/or situation as a training method allows participants to work through problems using a common body of information. This method is particularly useful when it is necessary to use a kind of information participants do not yet have available, such as community assessment data. In addition, a simulated community or situation provides a simplification of a problem situation and focuses on a learning experience that can later be applied to a more complex reality situation.

Written Exercises

Activities calling for written responses of various kinds are used in some of the sessions to stimulate the participants to formulate conclusions individually. Written exercises provide participants with a useful record of work done during the training program. Also, some individuals seem to learn better by writing than by listening, talking, or reading. The written

exercises should not be "assignments" to be completed for their own sake. Rather, regard them as springboards for relevant discussions. Do not let the participants become bogged down in the details of the exercise to the extent that they waste time or lose interest.

Small Group Work

The plans for some sessions suggest that the participants break up into small groups to work on specific problems and report back to the large group. It is useful, when possible, to have a variety of experience levels represented in the composition of each unit.

Some trainers feel that allowing groups to remain stable throughout the workshop or training program allows each to develop as a working unit; others feel that it is better to encourage more diverse interactions by forming new ones for each session. In this program groups are assigned around a common problem to facilitate shared learning. However, personality conflicts can interfere with group work. If strong divisiveness seems to be developing in a group or if a particular group is becoming a separate unit that might be difficult to lead, the trainer will probably want to reconstruct the groups for the following sessions.

Each group needs a recorder if a report is to be made. The trainer may either assign recorders when each group is formed or allow each to choose its own. It is a good idea in either case to have different individuals act as recorders in different sessions.

During small group activities the trainer circulates among groups to answer any questions, making sure that all the participants understand the activity, and ensure that the groups are on course in their discussions.

End the sessions early enough to allow sufficient time for follow-up discussions involving the whole group:

- begin the follow-up with the reports of the conclusions reached by each team;
- follow each report by a brief discussion and question period, but reserve the major portion of discussion time so that all the conclusions can be treated together in context.

Brainstorming

Calling on all members of a group to contribute ideas and suggestions quickly and randomly is termed brainstorming, a technique which quickly elicits input from a number of people and provides many different perspectives. In a brainstorming session, the trainer calls on the group members to present any ideas they may have in rapid succession and without contemplating them carefully. The suggestions are listed so that everyone can see them, usually on a chalkboard, a flipchart, or a blank sheet of acetate for use with an overhead projector. Then cull the ideas for relevancy, redundancy, or appropriateness. Each contribution is written down initially, and the group goes back later to consider which apply and which should be discarded. This activity can be very creative, since the ideas of one person often help stimulate the thinking of others.

Use of Audiovisual Equipment

The expert use of transparencies, filmstrips, and other audiovisual media contributes immeasurably to any training event. Attention is focused on key issues, major principles are highlighted, and difficult concepts are presented visually and concisely. Careful integration of audiovisual materials with the content will quicken the pace of the presentation and enliven the training event. On the other hand, audiovisual materials can seriously disrupt a presentation if the trainer is inept in the use of the equipment. Fumbling with transparencies

that are out of sequence, searching for an extension cord, fiddling with the projector, or having a filmstrip out of synchronization with the sound track are problems that inevitably will plague the ill-prepared trainer. As a result, the pace of the session lags and the group's interest wanes.

PLANNING GUIDELINES

In preparing to utilize this package the trainer may benefit by considering the following checklist of tasks to complete:

1) Review the material:

   – Participant's Manual content;

   – Trainer's Manual content.

2) identify and/or review the training needs of the potential target group(s) (see Intro Unit for guidelines), in terms of tasks they need to perform;

3) select ACT package material according to:

   – training needs;

   – program objectives;

   – time available;

   – participants available;

   – trainer resources available;

   – job requirements;

   – management objectives;

   – cultural/community factors;

   – consultation with potential participants;

   – local circumstances

4) assemble a draft outline of the program, using ACT and other materials required (Appendix B);

5) use ACT materials to help select and brief resource persons;

6) select/recruit potential participants;

7) send draft program outline to potential participants;

8) interview potential participants vis-a-vis draft program and their needs/ expectations;

9) modify program based on feedback as above;

10) practise delivery of program;

11) review overall program at first session, with participants;

12) make adjustments where desirable and possible;

13) obtain specific participant feedback daily, and at the end of the program, to further refine it (see module 4 of Introduction Unit):

As noted on the previous page, Appendix B is provided as a tool for selecting, organizing and locating training resources from the ACT package and elsewhere.

APPENDIX B

GUIDE TO SELECTING AND USING TEACHING MATERIALS

INTRODUCTION	HANDOUTS	VISUALS	EXERCISES	FILMS OR CASSETTES	EQUIPMENT	RESOURCES (Human/ material)
Module 1 Rationale						
Module 2 Objectives						
Module 3 Content						
Module 4 Training Needs						

UNIT I Communica. Skills	HANDOUTS	VISUALS	EXERCISES	FILMS OR CASSETTES	EQUIPMENT	RESOURCES (Human/ material)
Module 1 Orientation						
Module 2 Reflective Skills						
Module 3 Directive Skills						
Module 4 Observations and Conclusions						

UNIT II Drug Concepts	HANDOUTS	VISUALS	EXERCISES	FILMS OR CASSETTES	EQUIPMENT	RESOURCES (Human/ material)
Module 1 Drugs						
Module 2 Hazards						
Module 3 Risk Indicators						
Module 4 Case Applications						

APPENDIX B

GUIDE TO SELECTING AND USING TEACHING MATERIALS

UNIT III Interview Methods	HANDOUTS	VISUALS	EXERCISES	FILMS OR CASSETTES	EQUIPMENT	RESOURCES (Human/ material)
Module 1 Assessment						
Module 2 Interview						
Module 3 Simulation						
Module 4 Assessment Documentation						

UNIT IV Treatment Planning	HANDOUTS	VISUALS	EXERCISES	FILMS OR CASSETTES	EQUIPMENT	RESOURCES (Human/ material)
Module 1 Functional Analysis						
Module 2 Modalities						
Module 3 Matching						
Module 4 Continuing Care/ Management						

APPENDIX C

THE NOMINAL GROUP TECHNIQUE: APPLICATIONS FOR TRAINING NEEDS ASSESSMENT[4]

Nominal Group Technique (NGT) Concept

"A method of generating ideas in a situation where the participants do not fully understand or agree upon the nature of the problem or how to solve the problem". It:

- identifies elements of a problem's situation;
- identifies elements of a problem's solution;
- establishes priorities.

NGT procedure for a structured group meeting

Five to nine individuals sit around a table (or are convened by conference telephone). Initially no talking takes place. Each individual has a sheet of paper with a nominal question at the top. This question is the focus of the meeting and is carefully formulated ahead of time in order to generate the required information. For example: "What specific skills and/or knowledge are required to....?"

Phase I

Each individual (independently) writes down as many answers to the question as possible.

After several minutes of controlled and intense word effort, each member, in turn, presents one idea from his/her listing. These ideas are recorded and numbered on flipchart paper by the leader. No discussion or evaluation of the ideas takes place, other than for clarification. The listing continues until no more ideas are offered. This concludes the "nominal" phase of the meeting.

Phase II

Next, the leader conducts a thorough, structured discussion of each recorded idea for clarification and expression of support.

Phase III

From the nominal listing, with independent, private, and silent balloting, the ideas are rank ordered or rated.

Advantages of NGT

1) Appropriate people can be selected to participate, based on their experience, etc.;
2) cost is low;
3) maximizes participation and minimizes distraction;
4) avoids dominance by strong personalities;
5) encourages a shared commitment to objectives;
6) may be used at many levels. However, care should be taken to frame nominal questions carefully and clearly. Furthermore, facilitators must be interpersonally skilled.

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[4] Scott and Deadrick, (1982).

APPENDIX D

DEVELOPING A CURRICULUM (DACUM)

Developing a curriculum (DACUM) concept

A format for organizing knowledge/skills components according to three basic dimensions:

- — work roles/tasks;
- — areas of competence;
- — degree of difficulty.

DACUM chart format for specific training needs analysis

Areas of competence	Roles/Tasks	
	(less difficult)	*(more difficult)*

I   (basic)
II
III
IV
•
•
•   (specialized)

Procedure for generating DACUM

1) Use a variety of needs assessment procedures to identify specific knowledge/skills components required by a particular job;

2) utilize nominal group technique (NGT) or similar structured group process to prioritize training needs and begin to generate consensus;

3) write major knowledge/skills components on cards (one card for each item). Arrange cards according to the above framework;

4) circulate a typed draft of the DACUM chart to the participants in the nominal group for refinement and approval.

Application of DACUM

Use the DACUM chart as a guide to identifying components of a training curriculum, and select/develop learning materials/programs appropriate to instruction in each area identified.

The DACUM chart can also be utilized to continuously monitor new training needs as they emerge.

The DACUM chart should be updated periodically. In situations where new roles/work tasks are created, new DACUM charts can be developed.

SAMPLE
COMPETENCY CATEGORIZATION CHART
DRIVING A CAR

(An exercise in developing a DACUM)

AREAS OF COMPETENCE	(SIMPLE)	ROLES	(MOST COMPLEX)
	local errands	driving to work + highways & short trips	taxi driving & long distance trips
B Preparation to **A** drive **S** **I** Driving in **C** summer conditions		The material generated by Phase I must be distributed throughout a grid similar to this. In accomplishing this task, the raw material of Phase I must be specified in terms of skills or knowledge related to appropriate aspects of driving a car.	
S **P** Driving in **E** abnormal **C** conditions **I** **A** **L** **I** Special **Z** circumstances **E** **D**			

APPENDIX E

PROFILING AND TARGETING[5]
Training and Development Needs
A Summary and Review

Questions

1) Can the "problem" be solved by training?

2) What kinds of training and development activities are most needed?

Priority and perceived need for training activities are influenced by:

- turnover of staff;

- new products/programs;

- size of training budget;

- time-frames for design, production, and delivery of training programs;

- availability of "slick" training materials;

- complaints, or other "squeaky wheels"

While a focus on short-term or immediate training needs occurs in most programs, a long-term perspective must also be maintained to guide the organization's training investments for the future (programs, equipment, materials, facilities, and personnel).

Often reactive approaches to meeting training needs divert resources away from more vital priorities related to the organization's goals. Reactive approaches are thus inadequate for the following reasons:

- they are directed by short-term problems, and ignore long-term priorities;

- they are often based on limited information;

- they do not reflect an investment policy in training (therefore, they vary tremendously according to fiscal constraints);

- to ensure acceptance, they are often very general, so as to apply in a wide variety of situations, or they are "trendy";

- usually they do not receive enthusiastic endorsement, nor do they achieve long-lasting results.

To avoid reactive approaches, problems which can be solved through training must be distinguished from those for which training is inappropriate (e.g., policy determination, personnel problems, working conditions, etc.).

Content, structure, and strategies of a training program must be determined by a process of identifying, prioritizing, and making commitments to legitimate training needs (needs assessment).

Needs Assessment (the difference between "what should be" and "what is now").

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[5] Bernhard and DiPaolo, (98).

Approaches vary with situation (e.g., time, resources available). Techniques include:

- standardized surveys;
- structured and unstructured interviews, with selected personnel, at various levels;
- structured and unstructured meetings with key personnel (often upper-level management), e.g. nominal group techniques (see Appendix A);
- review of documents and work samples;
- on-site observations;
- review of research and thinking which is published in the particular field;
- combination of the above.

Each of these has strengths and weaknesses. The best approach, obviously, is the one which will most quickly and accurately target/profile long-term, high-priority training and development needs.

Systematic Technique for Assessing Resources and Training/Development (START) is a composite approach. Its activities are:

- *identify* training *needs* from multiple resources (noted above);
- *separate* training *problems* from non-training problems;
- sort the training/resources information in an *action framework* (e.g. DACUM format, see Appendix B);
- *rank* the *topics* to establish long-term programs;
- *build consensus* on *how/when* training needs are to be met.

START phases:

- *review* alternative data collection techniques;
- *consult* management and confirm selected strategies;
- *conduct* cycles of data collection and analysis;
- *sort/separate* training and non-training problems;
- *conduct structured meetings* to confirm and gain commitment on long-term training programs.
- review data;
- place topics in a long-term program (five years);
- establish commitment at all levels, consistent with organization goals.

Summary

This kind of approach

- increases your chances for gaining a clearer picture of needs for training, in line with organization goals;
- provides more comprehensive needs assessment results, covering more topics;
- uses more precise data, resulting in less arbitrary training decisions and a more professional image.

APPENDIX F

DACUM* TRAINING NEEDS ASSESSMENT CHECKLIST
FOR ASSESSMENT AND REFERRAL TASKS

		NEED IMPROVEMENT	OK	STRONG
I.	**COUNSELLING COMMUNICATIONS†**			
	– Interviewing			
	– Teaching			
	– Documenting/Reporting			
1.	Demonstrate reflective skills†			
	a) Attending†	___	___	___
	b) Paraphrasing†	___	___	___
	c) Summarizing†	___	___	___
	d) Reflects feelings†	___	___	___
2.	Demonstrate knowledge and use of relevant forms with emphasis on confidentiality	___	___	___
3.	Give feedback†	___	___	___
4.	Demonstrate directive skills†			
	a) Probing†	___	___	___
	b) Confrontation†	___	___	___
	c) Interpretation†	___	___	___
5.	Handle intoxicated clients	___	___	___
6.	Constructive termination of contact	___	___	___
7.	Orient client to screening interview	___	___	___
8.	Motivate client to participate†	___	___	___
9.	Track client (preappointment calls)	___	___	___
10.	Conduct screening interview†	___	___	___
11.	Inform client of resources available†	___	___	___
12.	Communicate screening observations to client	___	___	___
13.	Identify client/counsellor/attitudinal barriers†	___	___	___

"DACUM" refers to "Developing a Curriculum" (Adams, 1975). Also, National Center for Alcohol and Education (1982).

Note: † items are covered in ACT

		NEED IMPROVEMENT	OK	STRONG

I. COUNSELLING COMMUNICATIONS†
(Cont'd.)

		NEED IMPROVEMENT	OK	STRONG
14.	Orient client to assessment/referral process†	___	___	___
15.	Conduct assessment interview(s)†	___	___	___
16.	Educate client re: Life areas†	___	___	___
17.	Conduct supportive (case management) interview(s)†	___	___	___
18.	Participate in case conferences†	___	___	___
19.	Write referral/follow-up reports to treatment services	___	___	___

II. PRACTICAL DRUG CONCEPTS†
- Identify and evaluate client chemical use
- Application of a range of chemical dependency theories
- Application of research findings re: chemical dependency

		NEED IMPROVEMENT	OK	STRONG
1.	Recognize chemical abuse cues†	___	___	___
2.	Identify major categories of chemical abuse†	___	___	___
3.	Demonstrate knowledge and use of relevant paper and pencil tests	___	___	___
4.	Identify major combinations of chemical abuse, e.g., toxic interactions†	___	___	___
5.	Interpret/report findings to next level care	___	___	___
6.	Determine nature and extent of chemical use†	___	___	___
7.	Demonstrate knowledge of major drug actions and interactions†	___	___	___
8.	Provide verbal feedback to client re: assessment/referral information†	___	___	___

Note: † items are covered in ACT

	NEED IMPROVEMENT	OK	STRONG

II.   PRACTICAL DRUG CONCEPTS†
(Cont'd.)

	NEED IMPROVEMENT	OK	STRONG
9. Determine consumption risk levels, (e.g., Risk-O-Graph)†	____	____	____
10. Identify client's perspective of chemical abuse†	____	____	____

III.   INITIAL INTERVIEW METHODS†
 –   Data gathering
 –   Interpret findings
 –   Synthesis of data

	NEED IMPROVEMENT	OK	STRONG
1. Ask: 4 basic questions:†			
a) What chemicals†	____	____	____
b) Amount used†	____	____	____
c) When used†	____	____	____
d) Consequences†	____	____	____
2. Knowledge and understanding of ethical and legal standards	____	____	____
3. Evaluate screening observations†	____	____	____
4. Ability to adapt assessment processes to individual clients†	____	____	____
5. Write psychosocial history†	____	____	____
6. Identify individual client's life area needs†	____	____	____
7. Demonstrate ability to apply functional analysis of client's chemical use†	____	____	____
8. Conduct comprehensive assessment (e.g., ASIST)†	____	____	____
9. Understand elements of case management†	____	____	____
10. Demonstrate ability to analyse relapse potential†	____	____	____
11. Priorize life area needs†	____	____	____

Note: † items are covered in ACT

		NEED IMPROVEMENT	OK	STRONG

IV. TREATMENT PLANNING STRATEGIES†
- Knowledge of and ability to use community resources
- Negotiation of treatment plan
- Selection of interventions

		NEED IMPROVEMENT	OK	STRONG
1.	Demonstrate knowledge of assessment/ referral resources†	___	___	___
2.	Negotiate next step with client†	___	___	___
3.	Identify key significant people in client's life†	___	___	___
4.	Refer client to appropriate resources†	___	___	___
5.	Knowledge of continuum of care e.g.,† a) outpatient† b) daycare† c) inpatient†	___ ___ ___	___ ___ ___	___
6.	Identify support and follow-up resources†	___	___	___
7.	Demonstrate knowledge of treatment resources and admission criteria†	___	___	___
8.	Involve client in treatment planning process†	___	___	___
9.	Develop relapse prevention plan†	___	___	___
10.	Identify need for crisis intervention†	___	___	___
11.	Summarize client data and interview process information†	___	___	___
12.	Work effectively with treatment personnel	___	___	___
13.	Assist client in problem identification and priorization†	___	___	___
14.	Link client to care systems†	___	___	___
15.	Identify options available†	___	___	___
16.	Identify and document gaps in service	___	___	___
17.	Facilitate coordination among treatment resources	___	___	___

Note: † items are covered in ACT

	NEED IMPROVEMENT	OK	STRONG

IV. TREATMENT PLANNING STRATEGIES†
(Cont'd.)

18.   Negotiate a written treatment plan†   ____   ____   ____

19.   Match client to relevant resources†   ____   ____   ____

20.   Monitor client's progress and modify plans   ____   ____   ____

21.   Other (fill in below)

_____   ____   ____   ____
_____   ____   ____   ____
_____   ____   ____   ____
_____   ____   ____   ____

All of the above can be organized on one DACUM. (See DACUM CHART on next page.)

COMPETENCY PROFILE (DACUM) CHART I
ASSESSMENT AND REFERRAL

AREAS OF COMPETENCE	CASE IDENTIFICATION	CASE MANAGEMENT

I. COUNSELLING COMMUNICATION
- INTERVIEWING
- TEACHING
- DOCUMENTING/REPORTING

Case Identification
1. Demonstrate reflective skills a) Attending b) Paraphrasing c) Summarizing d) Reflects feelings
2. Demonstrate knowledge and use of relevant forms with emphasis on confidentiality
3. Give Feedback
4. Demonstrate directive skills a) Probing b) Confrontation c) Interpretation
5. Handle Intoxicated Clients
6. Constructive termination of contact
7. Orient client to screening interview
8. Motivate client to participate
9. Track client (preappointment calls)
10. Conduct screening interview
11. Inform client of resources available
12. Communicate screening observations to client

Case Management
13. Identify client/counsellor attitudinal barriers
14. Orient client to assessment/referral process
15. Conduct assessment interview(s)
16. Educate client re: Life areas and chemical abuse
17. Conduct supportive (case management) interview(s)
18. Participate in case conferences
19. Write referral/follow-up reports to treatment serv.

II. PRACTICAL DRUG CONCEPTS
- IDENTIFY & EVALUATE CLIENT CHEM. USE
- APPLICATION OF A RANGE OF CHEM. DEPENDENCY THEORIES
- APPLICATION OF RESEARCH FINDINGS RE: CHEM. DEPENDENCY

Case Identification
1. Recognize chemical abuse cues
2. Identify major categories of chem. of abuse
3. Demonstrate knowledge and use of relevant paper and pencil tests
4. Identify major patterns of chem. of abuse, e.g. toxic interactions
5. Interpret/report findings to next level care
6. Determine nature and extent of chem. use
7. Demonstrate knowledge of major drug actions and interactions.

Case Management
8. Provide verbal feedback to client re: assmnt/referral info.
9. Determine consumption risk levels, e.g. Risk-O-Graph
10. Identify client's perspective of chem. abuse

III. INITIAL INTERVIEW METHODS
- DATA GATHERING
- INTERPRET FINDINGS
- SYNTHESIS OF DATA

Case Identification
1. Ask: 4 basic questions: a) What chemicals b) Amount used c) When used d) Consequences
2. Knowledge and understanding of ethical and legal standards
3. Evaluate screening observations
4. Ability to adapt assessment processes to individual clients
5. Write psychosocial history
6. Identify individual client's life area needs

Case Management
7. Demonstrate ability to apply functional analysis of client's chemical use
8. Conduct comprehensive assessment e.g. A.S.I.S.T.
9. Understand elements of case management
10. Demonstrate ability to analyse relapse potential
11. Priorize life area needs

IV. TREATMENT PLANNING STRATEGIES
- KNOWLEDGE OF AND ABILITY TO USE COMM. RESOURCES
- NEGOTATION OF TREATMENT PLAN
- SELECTION OF INTERVENTIONS

Case Identification
1. Demonstrate knowledge of assessment/referral resources
2. Negotiate next step with client
3. Identify key significant people in client's life
4. Refer client to appropriate sources — Understanding of policies and procedures manual
5. Knowledge of continuation of care e.g. a) outpatient b) daycare c) inpatient
6. Identify support and follow-up resources
7. Demonstrate knowledge of treatment resources and admission criteria
8. Involve client in treatment planning process
9. Develop relapse prevention plan

Case Management
10. Identify need for crisis intervention
11. Summarize data and process information
12. Work effectively with treatment personnel
13. Assist client in problem identification and prioritzation
14. Link client to care systems
15. Identify options available
16. Identify and document gaps in service
17. Facilitate coordination among treatment resources
18. Negotiate a written treatment plan
19. Match client to relevant resources
20. Monitor client's progress and modify plans

April, 1985

APPENDIX G

ADDICTION COUNSELLING TRAINING (ACT)
SAMPLE FEEDBACK FORM*

		RATING				
SESSIONS		STRONGLY DISAGREE		STRONGLY AGREE		
1. INTRODUCTION	Contents are useful	1	2	3	4	5
1.1 " RATIONALE	Presentation was well done	1	2	3	4	5
1.2 " GET ACQUAINTED	Exercise was useful	1	2	3	4	5
1.3 " ORIENTATION	Discussion was well done	1	2	3	4	5
1.4 " TRAINING NEEDS	Leadership was helpful	1	2	3	4	5
2. COUNSELLING SKILLS	Contents are useful	1	2	3	4	5
2.1 " ORIENTATION	Contents are useful	1	2	3	4	5
2.2 " REFLECTIVE	Presentation was well done	1	2	3	4	5
" "	Exercises were useful	1	2	3	4	5
2.3 " DIRECTIVE	Contents are useful	1	2	3	4	5
" "	Presentation was well done	1	2	3	4	5
" "	Exercise was useful	1	2	3	4	5
2.4 " CONCLUSIONS	Leadership was helpful	1	2	3	4	5
3. PRACTICAL DRUG CONCEPTS	Dependency Exercise was useful	1	2	3	4	5
3.1 " DRUGS	Contents are useful	1	2	3	4	5
" "	Presentation was well done	1	2	3	4	5
3.2 " HAZARDS	Contents are useful	1	2	3	4	5
" "	Presentation was well done	1	2	3	4	5
3.3 " RISK INDICATORS	Contents are useful	1	2	3	4	5
" "	Presentation was well done	1	2	3	4	5
3.4 " CASE APPLICATION	Exercise was helpful	1	2	3	4	5
4. INITIAL INTERVIEW	Simulation Exercise was useful	1	2	3	4	5
4.1 " ASSESSMENT	Contents are useful	1	2	3	4	5
" "	Presentation was well done	1	2	3	4	5
4.2 " INTERVIEW	Contents are useful	1	2	3	4	5
" "	Presentation was well done	1	2	3	4	5
4.3 " SIMULATION	Contents are useful	1	2	3	4	5
" "	Presentation was well done	1	2	3	4	5
4.4 " ASSESSMENT DOCUMENTATION	Presentation was well done	1	2	3	4	5
" "	Documents were helpful	1	2	3	4	5
5. TREATMENT PLANNING	Warmup Exercise was useful	1	2	3	4	5
5.1 FUNCTIONAL ANALYSIS	Contents are useful	1	2	3	4	5
" "	Presentation was well done	1	2	3	4	5
5.2 " MAJOR MODALITIES	Contents are useful	1	2	3	4	5
" "	Presentation was well done	1	2	3	4	5
5.3 " MATCHING	Contents are useful	1	2	3	4	5
" "	Presentation was well done	1	2	3	4	5

*Note: Ideally the above items should be answered immediately after delivery of each module.

	STRONGLY DISAGREE			STRONGLY AGREE	

5.4 " CONTINUING CARE/
     MGT.

	STRONGLY DISAGREE				STRONGLY AGREE
Contents are useful	1	2	3	4	5
Presentation was well done	1	2	3	4	5

6.   PRE-READING
       "   "

Contents are useful OVERALL	1	2	3	4	5
" " " UNIT I	1	2	3	4	5
" " " UNIT II	1	2	3	4	5
" " " UNIT III	1	2	3	4	5
" " " UNIT IV	1	2	3	4	5

	VERY POOR			VERY GOOD	

7.   THE ACT PROGRAM AS A
    WHOLE   1 2 3 4 5

8.   GENERAL COMMENTS (below)
    8.1   ADDITIONAL TRAINING
          NEEDED IN THE
          FOLLOWING AREAS
    8.2   OTHER COMMENTS

APPENDIX H

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COUNSELLING
COMMUNICATION SKILLS

UNIT I
COUNSELLING/COMMUNICATION SKILLS –
TRAINER'S MANUAL
TABLE OF CONTENTS

INTRODUCTORY PERSPECTIVE

The purpose of this Unit is to teach specific skills which are the foundation for successful counselling interventions. To be effective, face-to-face *counselling communications* require good interpersonal skills. That is, in order to establish a positive climate and relationship for counselling, counsellors need to be able to demonstrate that they are listening to and empathically understanding a client's concerns. They also need to be able to clarify, validate, and direct the flow of communication so that the client's concerns as well as objective facts are taken into consideration.

This Unit provides a useful approach to introducing, practising, and (for some) reviewing these crucial interpersonal skills. Included are basic knowledge, exercises, demonstrations, and practice sessions for each skill, without emphasizing the content or special problems associated with counselling drug-abusing clients. A demonstration videotape is also available.

Although the time allowed is *not* sufficient to master the skills, the Participant's Manual provides source material for continued practice and self-monitoring. Participants should be encouraged to arrange for supervised practice of these skills until they have mastered them sufficiently. Users of this module, as with others in this package, should assume that MUCH MORE TIME and PRACTICE are needed to adequately learn the concepts and skills presented. Thus, the need for CONTINUED TRAINING as discussed in Module 4 of the Introductory Unit.

Before beginning this Unit, trainers must ensure that they have completed the following three preparatory steps:

1) The trainer should have read the training manual and accompanying appendices thoroughly to ensure a sound understanding of content.

2) The trainer should have a "dry run" with all materials (e.g., videotapes), instructions, and exercises that they are not absolutely familiar with. This will ensure that trainers fully understand the training methodology.

3) The trainer should gather all materials and equipment needed beforehand and test them to ensure a smooth flowing training session. This is particularly critical with regard to audio-visual equipment to ensure knowledge of operation and compatibility of videotapes with playback units.

A sample schedule for this Unit has been included in pages I-7 to I-8. If trainers choose to use that schedule, they must send out Participant's Manuals well ahead of the training event (e.g., two or three weeks) and ensure that participants receive and read their manuals prior to the event. (It may be advisable to telephone each participant about one week prior to the event to ensure that they have received the material and to emphasize how important it is to read it.)

If the trainer wishes to expand the time-frame for this Unit, time could be allowed for segments of the manual to be handed out and read during the session time.

A final comment relates to the structure of the Unit. It has been constructed so that it may be used as a whole, or modules may be independently selected for use on their own.

OBJECTIVES

COUNSELLING/COMMUNICATION SKILLS
MODULE 1: ORIENTATION TO UNIT I

Goals/Objectives

The goal of this module is to describe and preview the communication concepts and skills contained in this Unit.

Upon completion of this module, participants should be able to explain the concepts of LISTENING, PROCESSING, AND RESPONDING as they relate to REFLECTIVE and DIRECTIVE COUNSELLING SKILLS.

MODULE 2: REFLECTIVE SKILLS

Goals/Objectives

The goal of this module is to familiarize participants with FOUR REFLECTIVE COUNSELL-ING SKILLS needed to actively listen to clients (ATTENDING, PARAPHRASING, REFLECTION OF FEELING, SUMMARIZING).

By the end of this module, participants should be able to:

– discriminate between and list the components of the four reflective counselling skills;

– demonstrate each of the four reflective counselling skills in a simulated counselling exercise.

MODULE 3: DIRECTIVE SKILLS

Goals/Objectives

The goal of this module is to familiarize participants with three directive counselling skills needed to focus and clarify clients' perception of their situation (PROBING, INTERPRETA-TION and CONFRONTATION).

By the end of these sessions, participants should be able to:

– discriminate between and list the components of directive counselling skills;

– demonstrate the three directive counselling skills in a simulated counselling exercise.

MODULE 4: OBSERVATIONS AND CONCLUSIONS

Goals/Objectives

The goal of this module is to ensure closure of the material and process of Unit I. Upon completion of this module participants should have:

– a working knowledge of reflective and directive counselling skills;

– identified the skills in which they require further practice.

SAMPLE SCHEDULE

UNIT I: COUNSELLING/COMMUNICATIONS SKILLS

SAMPLE TIMES	TIME REQUIRED	TITLE	ACTIVITY/ FORMAT	MATERIALS	PAGE
9:00	25 min.	**Module 1**	Activity A – "Orientation" – Large group – Lecture – Discussion	– Flipchart/blackboard – felt pens/chalk	I-11 to I-13
9:25	60 min.	**Module 2**	Activity A – "Reflective Counselling Skills" – Small group Exercise	– Skill category cards (one set of four for each small group) (Appendix A) – client/counsellor interaction cards in duplicate (one set of 15 for each participant in each small group (Appendix B)	I-17 to I-19
			Activity B – "Reflective Counselling Skills" – Large group – Lecture – Small group – Mini-exercises	– Flipchart/ blackboard. – client/counsellor interaction cards. (Appendix B) – felt pens/chalk	I-20 to I-25
10:25	20 min.	BREAK			
10:45	20 min.		Activity C – "Reflective Counselling Skills" Large group Skill demonstration	– Video playback unit, demonstration tape – "Communication Skills – A Demonstration Tape" (16 minutes) Available from the Addiction Research Foundation of Ontario on loan. – Counsellor Response Recording Forms (Appendix E)	I-25 to I-26
11:05	55 min.		Activity D – "Reflective Counselling Skills" – Small group – Practice session		I-27 to I-28

SAMPLE TIMES	TIME REQUIRED	TITLE	ACTIVITY/ FORMAT	MATERIALS	PAGE
12:00	60 min.	LUNCH			
1:00	30 min.	**Module 3**	Activity A – "Directive Counselling Skills" – Large group – Lecture	– Blackboard/flipchart – felt pens/chalk	I-31 to I-33
1:30	30 min.		Activity B – "Reflective Counselling Skills" – Large group	– Video playback unit – "Communication Skills – A Demonstration Tape" Available from the Addiction Research Foundation of Ontario. (see module 2)	I-33 to I-34
2:00	90 min.		Activity C – "Reflective Counselling Skills" – Small group – Large group – Practice session		I-35 to I-36
3:30	15 min.	BREAK			
3:45	Approx. 30 min.	**Module 4**	Activity A – "Observations and Conclusions" – Large group	– Blackboard/flipchart – felt pens/chalk	I-39 to I-40

Module 1: ORIENTATION

EXPLAIN THE CONCEPTS:

Attending

Paraphrasing

Reflection of Feeling

Summarizing

Listening

Processing

Responding

Probing

Interpretation

Constructive Confrontation
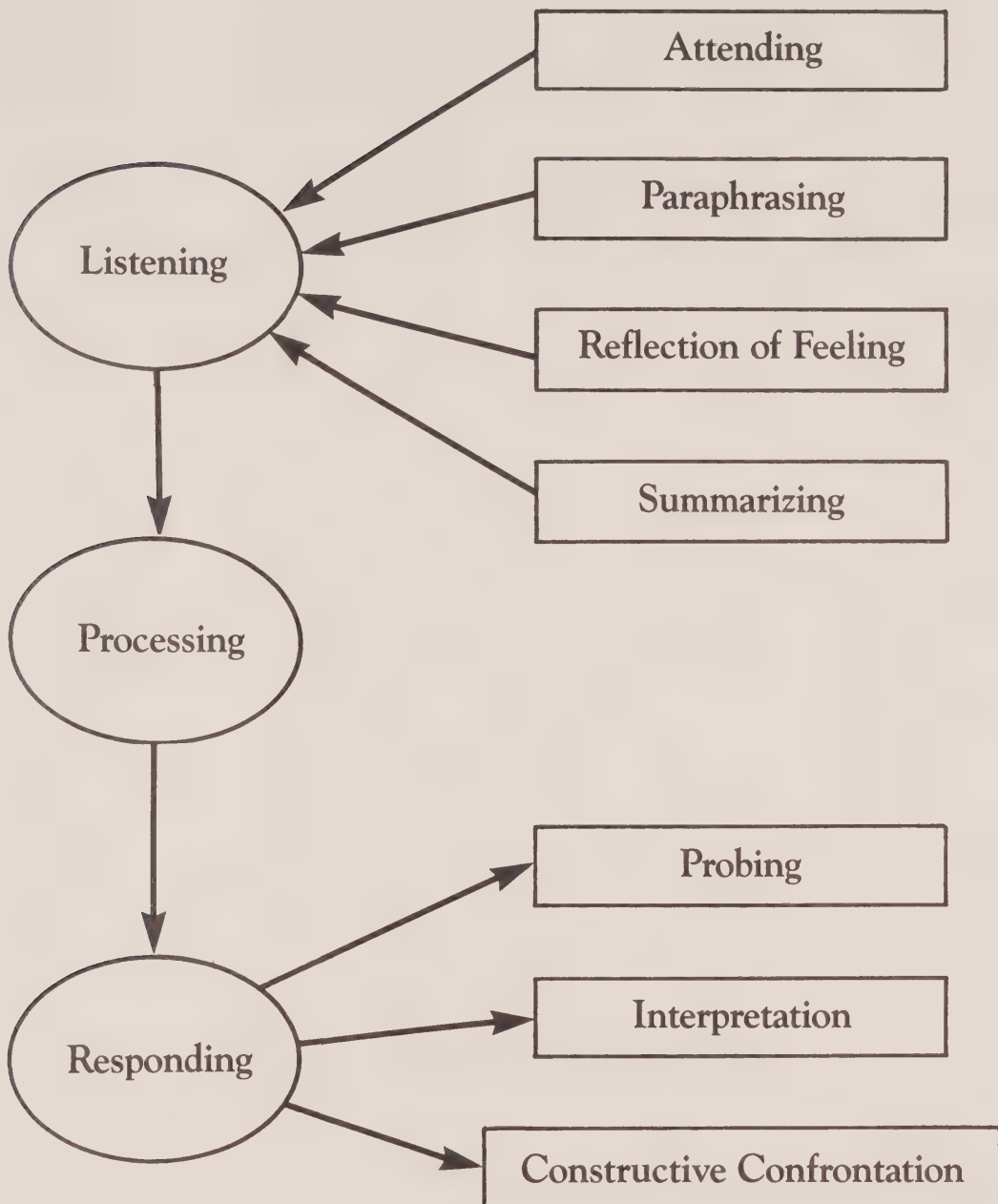
Module 1: ORIENTATION

OVERVIEW OF MODULE 1: ORIENTATION TO UNIT I

Time required	25 minutes (to complete Activity A)
Format	Large Group
Supportive materials	– Flipchart/blackboard – felt pens/chalk
Learning objective	At the conclusion of this module, participants should be able to explain the concepts of LISTENING, PROCESSING and RESPONDING as they relate to REFLECTIVE and DIRECTIVE COUNSELLING SKILLS.

See Participant's Manual, Pages I-7 to I-9.

ACTIVITY A

ORIENTATION TO UNIT I

Time required	25 minutes
Format	Large group – Lecturette and discussion.
Supportive materials	– Flipchart/blackboard – visual on page – felt pens/chalk
Learning objectives	1) Ensure that participants can explain the concepts of listening, processing and responding.
	2) Ensure that participants can list two categories of counselling skills (reflective and directive) and the purpose of these skills in the counselling process.

Instructions For Training Activity A

During this 25-minute segment, the trainer should briefly review the material covered in the Introduction section of the Participant's Manual, pages I-6 to I-8. Since the material is to have been read by by participants prior to the beginning of the program, asking participants to define terms involved is recommended as one alternative to a lecturette.

Trainers are encouraged to develop innovative approaches to reviewing this material quickly once they are experienced with this Unit.

The trainer should stress from the outset that these counselling skills are only effective in the context of:

- adequate specialized counselling knowledge;

- acceptable ethical standards, e.g., confidentiality;

- constructive attitudes toward helping clients, e.g., empathy, concreteness, immediacy, and positive regard for clients.

As a final point, the trainer, by using the visual on page I-9 should ensure that the key points listed on page I-12 of this training manual are well understood by participants.

(See pages I-6 to I-8 in Participant's Manual.)

Key Points

1) Counselling is a form of communication involving: LISTENING – PROCESSING – RESPONDING;

2) The focus of Unit I is: LISTENING and RESPONDING;

3) Skills involved in LISTENING and RESPONDING are broken into REFLECTIVE and DIRECTIVE COUN-SELLING SKILLS for the purpose of this program;

4) The FOUR REFLECTIVE COUNSELLING SKILLS of this program are: ATTENDING; PARAPHRASING; REFLECTION OF FEELING; SUMMARIZING.

5) The THREE DIRECTIVE COUNSELLING SKILLS[6] of this program are: PROBING; INTERPRETATION; CONFRONTATION.

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[6]SELF-DISCLOSURE as a directive counselling skill is not included here but should be noted as an important issue in training, either in the practice sessions or added as an additional module. Because of its "sensitive" nature, it is difficult to deal with in a brief training module. (See National Centre for Alcohol Education, 1982)

6) Sequence of events for Unit I is:
    ORIENTATION;
    REFLECTIVE COUNSELLING SKILLS (Knowledge);
    VIDEOTAPE OF REFLECTIVE SKILLS (Modelling);
    PRACTICE OF REFLECTIVE SKILLS (Practice);
    DIRECTIVE SKILLS (Knowledge);
    VIDEOTAPE OF BOTH REFLECTIVE AND DIREC-
    TIVE SKILLS (Modelling);
    PRACTICE OF BOTH TYPES OF SKILLS (Practice);
    CONCLUSION.

7) This Unit is an introduction to these skills – a very solid
    beginning, but simply a beginning. More practice,
    supervision and time must be devoted to these skills.
    (See Introduction Unit, Training Needs).

Module 2: REFLECTIVE COUNSELLING SKILLS

Attending

Paraphrasing

Reflection of Feeling
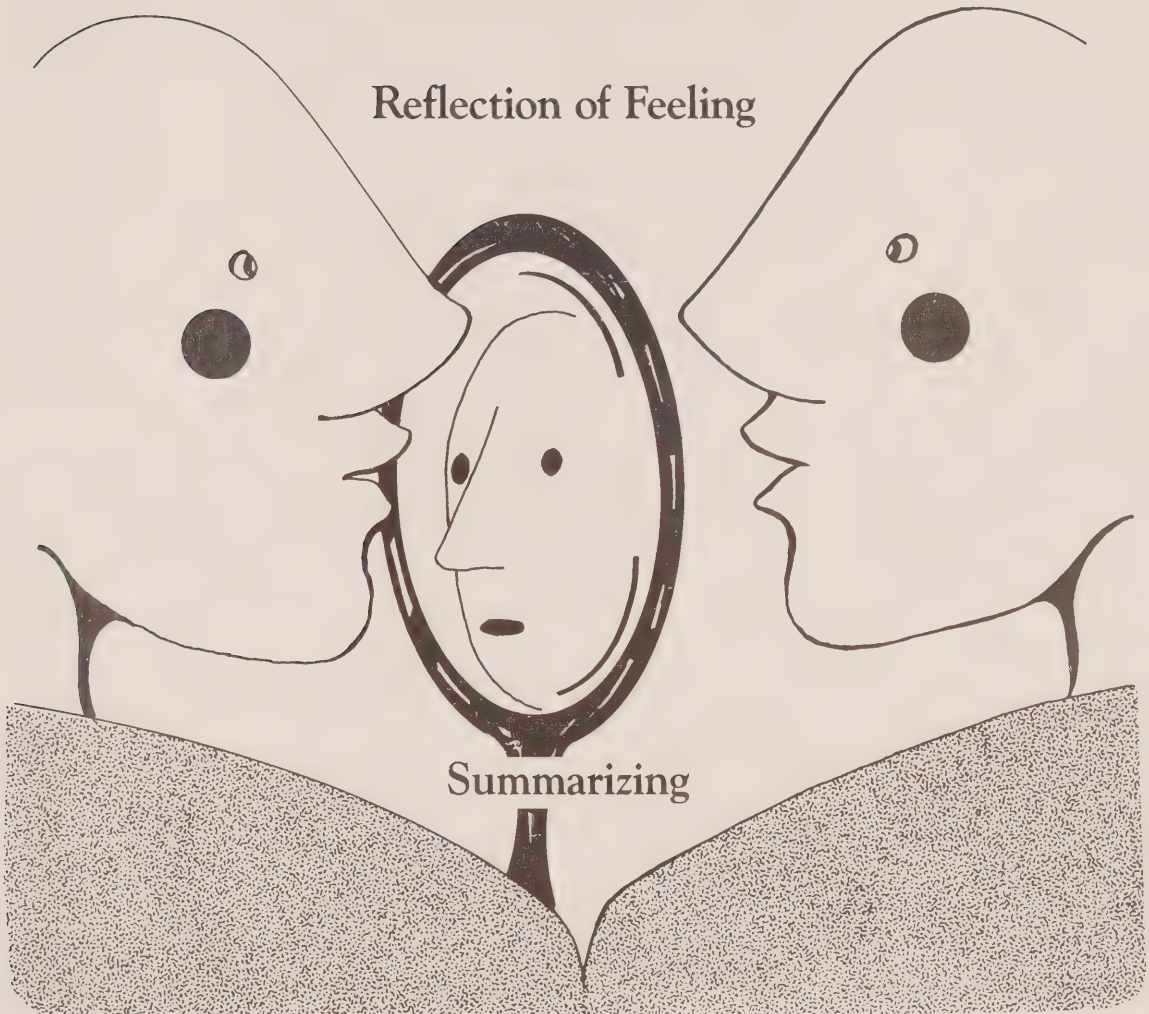
Summarizing

Module 2: REFLECTIVE COUNSELLING SKILLS

OVERVIEW OF MODULE 2: REFLECTIVE SKILLS

Time required	Two hours and fifteen minutes (to complete activities A or B and activities C and D.)
Format	– small group exercise – large group – lecturettes and mini-exercises – small group – large group
Supportive materials	– Skill category cards (one set of four for each small group) (Appendix A, Trainer's Manual) – client counsellor interaction cards (in duplicate – one set of 15 for each participant in each small group) (Appendix B, Trainer's Manual) – flipchart/blackboard – video playback unit, demonstration tape[7] (if available), and Counsellor Response Recording Forms (Appendix B, Participant's Manual) – felt pens/chalk
Learning objectives	At the conclusion of this module, participants should be able to: – discriminate between and list the components of the four reflective counselling skills; – demonstrate each of the four reflective counselling skills in a simulated counselling exercise.

ACTIVITY A*

REFLECTIVE SKILLS EXERCISE

Time required	60 minutes
Format	Small group – exercise.
Supportive materials	– Skill category cards (one materials set of four for each small group). (Appendix A, Trainer's Manual) – client/counsellor interaction cards (in duplicate – one set of 15 for each participant in each small group). (Appendix B, Trainer's Manual)

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[7] "Communication Skills: A Demonstration Tape" (16 minutes). Available from the Addiction Research Foundation of Ontario (purchase or loan).

* Activity A should be used with participants who have had little or no micro skills training. For those who have had previous training, use Activity B. (Page I-20).

Learning 1) To ensure that participants can list the key
objectives components of each reflective counselling skill.

2) To have participants demonstrate each of the four
reflective counselling skills in response to a
scripted client/counsellor sequence.

Note: Either activity A *or* B should be used (see below).

Instructions For Training Activity A (5 min.)

The trainer will conduct a 5-minute introduction in the large group
prior to breaking into small working groups.

The trainer will point out that the focus of this activity will
be on the four reflective counselling skills. The trainer will further
add that this process will begin with an exercise designed to provide
an opportunity to review, practise, understand and discuss these
skills. The exercise will be 50 minutes long and will be conducted
in groups of four to six.

The trainer will then:

– Divide the large group into smaller groups.
(Appendix C, Trainer's Manual).

– Ask participants to bring their Participant's Man-
uals with them to the small groups.

– Give instructions on where the small groups will
convene.

– Assign a leader to each of the small groups.

– Set a specific time for each group to return to the
large group.

– Disperse participants to the smaller groups.

NOTE: Each group leader must be knowledgeable in demonstrat-
ing, discussing, and using anecdotal material with respect
to each of the four skill areas. If you are not in the position
to supply such people, conduct your first training session
with a maximum of six people and work with them to
become resource persons for future presentations of this
package.

(See pages I-13 to I-24 in Participant's Manual)

Instructions Delivered in the Small Groups (5 min.)

The trainer should make the point that in this exercise, the quality
of counselling is not important. The purpose here is simply to
demonstrate the four reflective counselling skills. The trainer will
then follow the steps listed below.

1) Give each participant a card, (see Appendix A,
Trainer's Manual) with one of the reflective
counselling skills written on it. In addition the
card will include, as a reference for the partici-
pants, the appropriate page in their manual.
Participants will now be given three or four

minutes to review their respective skills in their manuals. If more than four participants are in the group, the "extras" may refer to any skills in which they feel they could use some quick review.

2) A separate series of cards (see Appendix B, Trainer's Manual: these cards are larger and not colour-coded) will have a series of client/counsellor statements written on each. The group leader will read the client statements (hence the need for duplicate cards) and the participant will read the counsellor responses. The last counsellor response is blank so that participants can verbally respond using the category of response on their skill category card. This process will begin with the person having the "attending" card. Once the "attender" has responded, he/she will state the key components of attending skills.[8]

The "paraphraser" will then respond to the same sequence using a paraphrase and stating its key components. This will be followed by the "reflector of feelings" and the "summarizer". If more than four participants are in the group, the remaining people may respond using any reflective counselling skill, but must identify it. This sets the stage for the exercise to move at a faster pace.

3) After each skill has been demonstrated, ask if there are questions. When all four skills have been applied to one client/counsellor card, ask each person to give their skill category card to the person on the right. Repeat the sequence, but you may leave out the key components if participants seem to understand them well. Continue the exercise until all participants can demonstrate the four reflective skills.

4) This exercise should move very quickly once the first two or three rounds are completed. The trainer should conclude the small group exercise by having the participants state the definitions of the four reflective skills and their key components. Throughout the first couple of rounds encourage questions and clarification-type discussion. Discourage discussion related to the relative merits of one response as being better than the other, as this will simply exhaust the time allotted. Ask participants to return to the large group when 50 minutes are up.

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8 For the key components of the four reflective counselling skills, refer to Participant's Manual:

— Attending, pages I-13 to I-15
— Paraphrasing, pages I-16 to I-18
— Reflection of feeling, pages I-18 to I-21
— Summarizing, pages I-22 to I-24

ACTIVITY B

REFLECTIVE COUNSELLING LECTURE AND EXERCISE

TRAINER'S NOTES

Time required	60 minutes
Format	Large group lecturette and mini-exercises, small group practice.*
Supportive materials	– Flipchart/blackboard. – felt pens/chalk.
Learning objectives	To ensure that participants can list the four reflective counselling skills, define in their own words each of these skills, and list the essential components of each of the four skills.

Instructions For Training Activity B

Activity B is divided into two parts – a 30-minute lecturette and a 30-minute exercise.

It is essential that participants read all of the relevant sections of their Participant's Manual before the trainer attempts to conduct activity B. Further, as noted at the beginning of this Unit, the trainer must be thoroughly familiar with all handouts, exercises, etc., before undertaking this activity and should develop a repertoire of humorous illustrations of each of the four reflective counselling skills.

The trainer will begin in the large group lecturette by emphasizing that this is a 30-minute review of what they have read and it is intended to help answer questions. For this reason, it is brief and will be relatively fast-moving.

The trainer will next draw the participants' attention to the learning outcomes of this sequence. These may be written on a flipchart and placed where all participants are able to read them, as noted below:

"By the end of this sequence, participants will be able to: list the four reflective counselling skills, define in their own words each of these skills, and list the essential components of each of the four reflective counselling skills."

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* Either activity A or activity B is to be used. Activity B may be better suited for participants who have had micro skills training before, but require a brief review.

Following this, the trainer should ask participants to list the four skills; write them on a flipchart. Next, ask participants why these skills are called reflective skills and what the title reflective implies.

It should be noted at this time that attending and paraphrasing usually take a little less time than reflection of feeling and summarizing. The trainer should be careful to monitor the use of time to ensure that all four skills are covered adequately. Remember, this is fast moving and is only allotted 30 minutes in total to cover the key points listed below for the four skills.

(See pages I-13 to I-24 in Participant's Manual)

Attending (under 5 minutes)

The trainer should begin by asking for a definition of "attending" and what its components are. (Use this sequence again for paraphrasing, reflection of feeling, and summarizing.) The key points to cover are listed below.

Key Points

1) Attending involves hearing and observing the verbal and nonverbal messages that the client is giving.

2) Attending involves communicating to the client that the counsellor is listening and understanding. This is accomplished through:

   a) eye contact

   b) body posture

   c) accurate verbal following

NOTE: When covering the four reflective counselling skills, the trainer may wish to use demonstrations and "mini-exercises" such as those listed below.

Mini-exercises/demonstrations of both good and bad attending

1) In the process of the presentation demonstrate examples of poor attending (e.g. turn away from a question, garble a question, etc.). Be careful to use examples which are appropriate to the level of rapport which has been established with participants.

2) Use participant behaviours to illustrate good attending while you are explaining a point, etc.

3) Use a brief staged role play with a participant demonstrating good and bad attending.[9]

4) A cartoon caricature (or comic strip cartoon sequence) on overhead to poke fun at poor attending may also be used.

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[9] A role play or cartoon featuring two people conversing, one looking over his/her shoulder as (s)he listens, could be used.

Paraphrasing (Under 5 minutes)

The trainer should begin by asking for a definition of paraphrasing and asking what its key components are. The following key points should be covered.

Key Points

1) Definition of paraphrasing – restating the content of client's verbal statement(s) (not nonverbal)

2) Determine the basic message

3) Re-phrase the message

4) Check it out.

5) The trainer may wish to use some exercises or demonstrations as listed below. Trainers are encouraged to develop their own in addition to these following examples.

Mini-exercises/demonstrations

1) Comic strip cartoon on overhead may be used to poke fun at bad Paraphrasing. [10]

2) Use an anecdotal story or three or four statements and ask participants to paraphrase (e.g. what happened on the way to…).

3) Staged role play – demonstration of good and bad Paraphrasing. [10]

4) a) Read out client statements and ask for a paraphrase of the statement.

   b) Same as (a) but also ask participants to first attend, then paraphrase.

Upon completion of paraphrasing move to reflection of feeling.

Reflection of feeling (5 – 6 minutes)

The trainer should begin by asking for a definition and/or key components. The following points should be covered:

Key Points

1) Definition of Reflection of Feeling – Stating the essence of the client's feelings either stated or implied, both verbal and nonverbal (very important).

2) Identify the feeling(s) being expressed

3) Formulate a response (at appropriate level and intensity).

4) Implicit checking out.

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[10] Person I – "I find you revolting. You are self-centred, overbearing and boring".

Person II – "So you're saying that you're not sure if you will go out with me on Saturday night".

NOTE: Feeling does *not* mean the same as opinion or judgment, as in "I feel he is too drunk to drive."

Mini-exercises/demonstrations (if the trainer wishes to use)

1) Cartoon comic strip[*].

2) Staged role play[*].

3) Do a demonstration – read a statement and put feeling into it nonverbally. Ask for identificaton of the feeling and for counsellor response (e.g., various treatments of "You told your husband", "You are separated now").

> [*] e.g.[11] Client: "I'm on top of the world today. I've got the job that I applied for and I start on Monday".

> Counsellor: "It sounds as if you are really happy to be working again."

Upon completion, move on to summarizing.

Summarizing (5 – 6 minutes)

Key Points

1) Definition of summarizing – A review of the main points expressed over a period of time.

2) Selection of the key points.

3) Tying them together.

4) Implicit or explicit checking out. (No assumptions, no advice-giving.)

Mini-exercises/demonstrations (if the trainer wishes to use)

1) Cartoons may be used, e.g. cut from newspaper and put on slides.

2) Do an advice-giving summary, (e.g. "Well, it seems to me that you should. Then with respect to him"; "Well just. And then tell him to. What do you think?"). Immediately do a "good" demonstrative summary for comparative purposes.

Upon completion, do a very rapid summary of the four skills as follows.

Summary of the four skills (approximately 2 – 5 minutes)

Ask participants to define each of the four skills and list their main components.

An alternative procedure could be to prepare in advance flipchart presentations with each skill defined and its main points listed. The trainer may simply refer to this material.

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[11] e.g. Client: "I'm on top of the world today. I've got the job that I applied for and I start on Monday."

Counsellor: "It sounds as if you are really happy to be working again."

Having completed this review of the four skills, the trainer will now move to have the participants practise some of the four reflective counselling skills in small working groups within the single large room. This practice time will take about 30 minutes and is divided as follows:

1) The trainer will begin by taking 2 or 3 minutes to explain to the large group that the purpose of this exercise is to expand and practise reflective counselling skills, the group leader introduces the exercise as such and requests that participants refrain from discussing the therapeutic merits of individual responses during the exercise. The focus remains on the correct formulation of reflective counselling skills. (It is accepted that different responses may be better or not quite as good as others with regard to clinical work.) The leader states the objectives of the exercise (refer to the flipchart).

   The trainer will then break the large group into groups of four to six participants (Appendix B). Each small group will have a group facilitator.

2) Once in the small group, the facilitator will take 5 or 6 minutes to make the following points:

   "Here we have a series of cards that are face down on the table. Each card has a client/counsellor interaction written on it". Ask a participant to pick up the first card and read out the statements.

(*NOTE*: Have simple statements for the first three or four cards.)

You (as the group facilitator) will respond using a reflective skill and identify which one it is.

Ask a participant for another reflective response, and have him/her identify what it is (e.g. attending, paraphrasing, etc.). Ask if there are any questions. If not, continue to explain the exercise as follows:

"We will now take about 15 minutes to conduct this exercise."

"Beginning on the left of the participant reading the card, each participant formulates a reflective counselling response to the statements read out and identifies which type of reflective skill it is. After one participant provides a reflective response, the next person must try to use a different type of reflective skill (i.e. first may attend, second may paraphrase, next may reflect feeling, next may summarize)."

If participants merely alternate between two categories, the group facilitator may ask for other categories of reflective counselling skills once each person has had an opportunity to respond reflectively to the statement.

Emphasize that it is important that participants keep this exercise moving and that each person not take too long to respond.

3) Ensure that the participants realize that in the case of some statements, it may not be appropriate to use all

four types of counselling reflective skills. If a participant can't generate a different reflective response, another one of the same type can be repeated in order to keep the process moving.

When the participant group have exhausted their repertoire of reflective skills, the next participant (to the left of the person who read the first card) picks up the next card in the pile and reads it out aloud. The sequence is repeated, moving to the left at each round.

    All participants should have the opportunity to read at least one card. Ask if there are any questions.

NOTE: After the first round, allow two or three minutes for questions and clarification. At this time, ensure that all participants understand the exercise and that no one is "lost" with regard to any of the skills. If they are, review the skill before proceeding. In this review, have other participants teach the material in order to ensure that they are not left out or bored while a few are catching up.

4)   Upon completion of the 15 minutes, debrief in the small group for about seven or eight minutes. Clarify any confusion regarding the four skills.

At this time, the small groups should reconvene to form a large group in order to move on to Activity C.

ACTIVITY C

SKILL DEMONSTRATION

Time required	20 minutes
Format	Large group.
Supportive materials	– Video playback unit, materials demonstration tape[*] (if available), and Counsellor response recording forms. (Appendix B, Participant's Manual)
Learning objectives	1) To demonstrate the objectives effective use of reflective counselling skills.
	2) To have participants recognize when discrete reflective skills are being applied in a simulated counselling sequence.

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[*]"Communication Skills: A Demonstration Tape" (16 minutes). Available from the Addiction Research Foundation of Ontario, (purchase or loan).

Training sequence (with videotape)

Instructions For Training Activity C

The trainer should take about five minutes to make the point that, when a videotape of a simulated client-counsellor interview is used, its purpose is not to provide a demonstration of excellent counselling, but rather to demonstrate competent and effective use of the four reflective counselling skills. It is an instructional demonstration, not an actual counselling interview.

The trainer should further describe that during the first portion (approximately 1.5 minutes) of the four-minute tape, each counselling reflective skill will be labelled, using a subtitle on the videotape. For the remainder of the tape, each counselling skill will be numbered and will be followed by a five-second pause in the tape immediately following each individual skill demonstration. Participants will be asked to correctly identify each skill and record it during the five-second pause delay, using the Counsellor response recording form, (Appendix B, Participant's Manual).

The trainer should run the tape through in its entirety allowing participants to record the skills as they appear. Then rerun the tape, asking participants to identify each skill and discuss concerns or incorrect answers.

It should be noted here that it is best to direct the discussion away from the therapeutic merits of the demonstration and focus on the identification of each counsellor response. During the discussion ensure that the participants understand why each response is a reflective skill.

In concluding, the trainer should note that this tape is a model for participants to follow in the next activity – Activity D.

(See pages I-13 to I-24 in Participant's Manual.)

Training sequence (without videotape)

Instructions For Training Activity C

If videotapes are not available, the trainer should demonstrate each reflective skill[12], in a live role play sequence, and then demonstrate each skill again, asking trainees to identify each skill, in writing and/or verbally.

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[12] A prepared script may be used.

(See pages I-13 to I-24 in Participant's Manual.)

ACTIVITY D

REFLECTIVE COUNSELLING SKILLS PRACTICE

Time required	55 minutes
Format	Small group
Supportive materials	None
Learning objective	To have each participant practise the four reflective counselling skills in client/counsellor role play situation.

Instructions For Training Activity D

The trainer should refer the participant to Appendix A, Participant's Manual, to review the concepts of constructive feedback.

In the large group, the trainer should take about five minutes to state that so far, we have:

- — observed each skill being demonstrated.

- — discussed the key components of each skill.

- — practised each reflective counselling skill in isolation.

Now we get to practise the skill ourselves.

(1) *In the large group*, the trainer should instruct participants that they are going to return to their same small groups (of four to six) with the group leader. The trainer should further state that in the small groups, each person will role play a client and each will role play a counsellor during the next 55 minutes. During the practice, the "counsellor" will be asked to use all four reflective counselling skills at least once. Each practice session should last approximately three minutes with three to four minutes of discussion on each. The "observers" are instructed to give feedback to the counsellor on his or her ability to demonstrate the use of reflective skills. Emphasize that we are not out to do "good counselling", but are only interested in ensuring that each participant can demonstrate the skills.

Ask if there are any questions. Instruct participants to return to the large group in 50 minutes in order that all may break for lunch together and in order to give the workshop leaders approximately five minutes to make

any pre-lunch announcements, etc. Note that this five-minute segment is not shown as a separate time on the schedule on page I-7. Disperse participants to their assigned small group practice areas. (Ask small group leaders to synchronize watches.)

2) Once in the small groups, each small group leader should select a volunteer for the client and counsellor roles. Pick candidates who are familiar with role plays and/or are among the least anxious about role playing in front of others.

3) Next assign the others to be observers and instruct them to give feedback to the players at the conclusion of each practice session.

4) The trainer should then give the participants the following instructions in the small group:

a) With regard to feedback, please ensure that:

i. feedback is to be helpful;

ii. feedback must be specific and descriptive rather than general or judgmental.

iii. feedback must be directed toward something that can be changed.

b) Ask each observer to pay specific attention to the four reflective counselling skills.

c) With each practice session, if necessary, re-emphasize that the purpose is to demonstrate the skills, not perform three-minute therapy.

The trainer should allow the first session to run for approximately three minutes. During the first session ensure that all observers and both actors are involved in the discussion. If someone is reticent, direct some specific comments to the person and explore the reluctance to participate.

Note: Return to the large group area on time. This will require the small group leaders to monitor time wisely to ensure that all participants are allowed the opportunity to role play and that groups do not run overtime.

(Refer to pages I-13 to I-24 in Participant's Manual.)

Module 3: DIRECTIVE COUNSELLING SKILLS

Constructive Confrontation
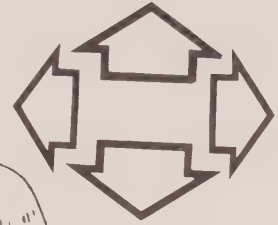
Interpretation

Probing
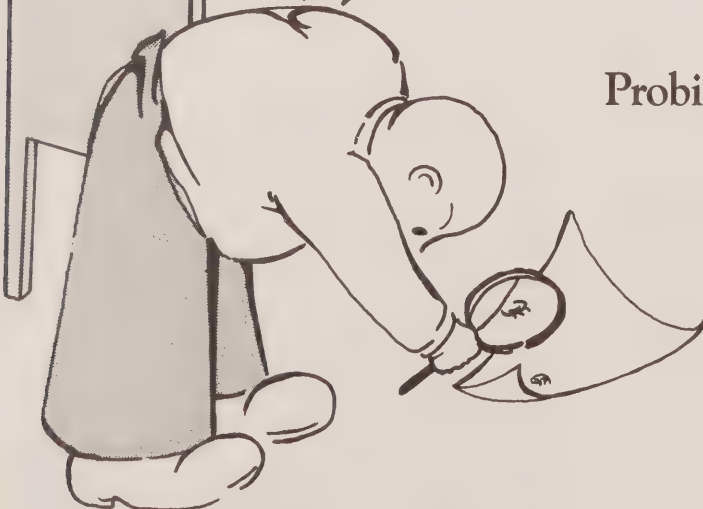
Module 3: DIRECTIVE COUNSELLING SKILLS

OVERVIEW OF MODULE 3:
DIRECTIVE COUNSELLING SKILLS

Time required
— Two-and-a-half hours (to complete Activities A, B, and C).

Format
— large group – lecturette
— large group small group

Supportive materials
— Blackboard/flipchart
— video playback unit, directive skills demonstration tape[13] (if available), and Counsellor response recording forms (Appendix B, Participant's Manual).
— felt pens/chalk

Learning objectives
By the end of these sessions, participants objectives should be able to:

— discriminate between and list the components of directive counselling skills;

— demonstrate the three directive counselling skills in a simulated counselling exercise.

ACTIVITY A

DIRECTIVE COUNSELLING SKILLS LECTURETTE

Time required
30 minutes

Format
Large group – lecturette.

Supportive materials
— Blackboard/flipchart.
— chalk/felt pens

Learning objectives
1) Ensure that participants objectives can explain the difference between reflective and directive counselling skills.

2) Ensure that participants can list the three directive counselling skills, define each in their own words, and list the essential components of each directive counselling skill.

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[13] "Communication Skills: A Demonstration Tape", available from the Addiction Research Foundation of Ontario, (see module 2).

Instructions For Training Activity A

NOTE: Participants will have read their Participant's Manuals prior to beginning this segment of the program. This segment is in effect a review of the material to ensure an understanding of the concepts. At this level, the trainer should be careful to keep the discussion at an academic understanding of these skills. Moving prematurely into demonstrating may be confusing to participants.

In the large group format it is suggested that the trainer follow the sequence of the six steps below. Remember, this should be a review and hence should be relatively fast-moving – the time allotment for this activity is 30 minutes.

(Parts 1, 2 and 3 should each take approximately five minutes to cover.)

1) Begin by asking participants to state what constitutes a directive counselling skill.

   Definition of directive counselling skills – Those types of responses which explicitly direct the client to examine or consider a specific issue or viewpoint.

2) Ask participants to differentiate between reflective and directive skills.

   Reflective responses are those counsellor responses which do not add new material to what the client has said and thus reflect information back to the client that has been received by the counsellor. *Directive* skills are those counsellor responses that either add new material to what the client has told the counsellor, or explicitly direct the client to explore a specific topic or a new perspective at greater length.

3) Ask participants to list the three directive skills.

   Probing, interpretation, and confrontation are the three directive counselling skills examined in this program.

4) Explore probing (approx. 5 min.)

   Definition of *probing* – The use of a question or statement to direct the client's attention and to explore his/her situation in greater depth.

   Components of probing:

   a) identification,

   b) open-ended phrasing.

5) Explore interpreting[14] (approx. 10 min.)

   Definition of *interpreting* – The use of a question or statement to help the client explore alternative ways of looking at a problematic situation. This may involve the addition of new material.

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[14] Interpreting responses are often phrased as highly focused probing questions.

Components of interpreting:

a) determining and restating the basic message;

b) adding a new frame of reference or directing the client to explore one;

c) checking out your intervention – does the new perspective have new validity for the client?

Two types of interpreting:

a) counsellor provides a new frame of reference;

b) counsellor directs the client to provide a new frame of reference.

Telling people what to do is not interpreting.

Explore confrontation[15] (approx. 10 min.)

Definition of *constructive confrontation* – exploring discrepancies that a client is presenting.

(with videotape)

ACTIVITY B

DIRECTIVE SKILLS DEMONSTRATION

Time required	30 minutes
Format	Large group.
Supportive materials	– Video playback unit, materials directive skills demonstration tape* (if available), and Counsellor · response recording forms. (Appendix B, Participant's Manual)
Learning objectives	1) To demonstrate the effective use of the three directive counselling skills (probing, interpreting and confrontation) as well as the four reflective counselling skills (attending, paraphrasing, reflection of feeling, and summarizing) in a simulated counselling situation.
	2) To provide an opportunity for participants to identify counselling skills in a simulated counselling situation.

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* "Communication Skills: A Demonstration Tape", available from the Addiction Research Foundation of Ontario, (see module 2).

[15] The trainer may wish to use mini-exercises to illustrate key points and to vary the process from a strictly question-and-answer format. For example, make a statement and ask someone to make a probing response to it (use of humorous statements can liven up discussion). An example of this process is seen in activity B of Reflective Counselling Skills, page I-20.

Counsellor should:

a) present specific evidence of the contradiction;

b) consider who is to benefit from the confrontation;

c) present the confrontation in a constructive manner;

d) consider timing and the stage of the client/ counsellor relationship.

The trainer shall conclude with: "Now that we have an understanding of these skills, we will now see a videotape and we will have the opportunity to see the various skills demonstrated."

Training Sequence (with videotape)

Instructions For Training Activity B

The trainer should take about five minutes in the large group to explain that we will be viewing a videotape of approximately 10 minutes in length. During the first portion (approximately 3.75 minutes) of the 10-minute tape, each counselling skill[16] will be labelled by a subtitle on the videotape. For the remainder of the tape, each counselling skill will be numbered and will be followed by a five-second pause in the tape immediately following each individual skill demonstration. Participants will be asked to correctly identify each skill and record it during the five-second delay using the Counsellor response recording form (Appendix B, Participant's Manual).

The videotape should be played through in its entirety without discussion or interruption and should then be rewound. The trainer should give a minute or so for participants to collect their thoughts; then the tape should be played through to the first counsellor response. Ask for a volunteer to identify it – discuss why the first response is .... and ensure that all participants understand. Repeat with each counsellor response. This total process should take about 30 minutes so the trainer ought to monitor the time if participants become involved in lengthy discussion.

Instructions For Training Activity B

If videotapes are not available, the trainer should demonstrate and identify each directive skill,[17] in a live role play sequence, and then demonstrate each skill again, asking trainees to identify each skill, in writing and/or verbally.

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[16] Some skills may be demonstrated less clearly than others. Differing perceptions of which skill is being shown can be used by the trainer to encourage useful discussion/clarification.

[17] A prepared script may be used, with participants taking part in role plays.

ACTIVITY C

DIRECTIVE SKILLS PRACTICE

Time required	90 minutes
Format	Small group. Large group.
Supportive materials	None.
Learning objectives	To provide an opportunity for participants to:

1) demonstrate reflective and directive counselling skills in a role play situation.

2) give and receive constructive feedback in a training situation regarding the demonstration of reflective and directive counselling skills.

Instructions For Training Activity C

The trainer should refer the participants to Appendix A, Participant's Manual, for a review of feedback if necessary.

In introducing this experiential sequence in the large group, the trainer should take three or four minutes to review all seven skills they have learned. The trainer should add that they are not to engage in an exercise of problem-solving, but are to attempt, during their practice, to demonstrate as many of the reflective and directive counselling skills as they can. When in the small groups, the small group leader should reiterate this message.

While observing the sessions, each observer may look for all skills, or each could be assigned specific skills on which to give feedback.

A variation of the standard practice session technique is to have the client face the entire small group and ask each person in turn to "counsel the client" (i.e. the total group counsels the client). Beginning at the left or right of the client, the first person begins with an opening statement and the client replies. The next person uses a counselling skill and the client replies, and so on, the idea being that each counsellor could be assigned a different category of skills. This allows participants to focus on skills that they may have some difficulty with. It also provides a break from the regular practice format. The group leader is encouraged to play a client in this version. Many variants of this theme are possible. For example, each time a counsellor makes a response, he/she could be prohibited from making that category of response again. This

change in the format does, however, mean that the client must be a reasonably quick thinker. An added benefit of this process is that with more than three or four people, the group has a larger pool of experience from which to create client scenarios in the practice sessions.

During the feedback segments of the role playing, the leader should take the time to clear up uncertainties that participants may have regarding the directive skills and make every attempt to have either himself or the group answer all questions.

An additional point for the trainer to consider at this time is that, once groups have been formed, the trainer must decide whether to keep the group members and leaders together for all exercises, or whether to rotate members.

There are advantages to either decision. One alternative is to rotate group leadership for each exercise. This tactic has many advantages of both alternatives regarding group membership rotation. Provided that the group leaders communicate among themselves well, this alternative may be the optimal choice.

Regardless of which variation the trainer uses, the group should conduct the role plays and, after the 90 minutes have elapsed, the leader should instruct all of the participants to come together in the large group. The trainer should convene a 15-minute break at this time.

(See pages I-36 to I-38 in Participant's Manual)

Module 4: OBSERVATIONS AND CONCLUSIONS

EXPLAIN THE CONCEPTS:

Attending

Paraphrasing

Listening

Reflection of Feeling

Summarizing

Processing

Probing

Interpretation

Responding

Constructive Confrontation

Constructive Confrontation

Interpretation

Probing
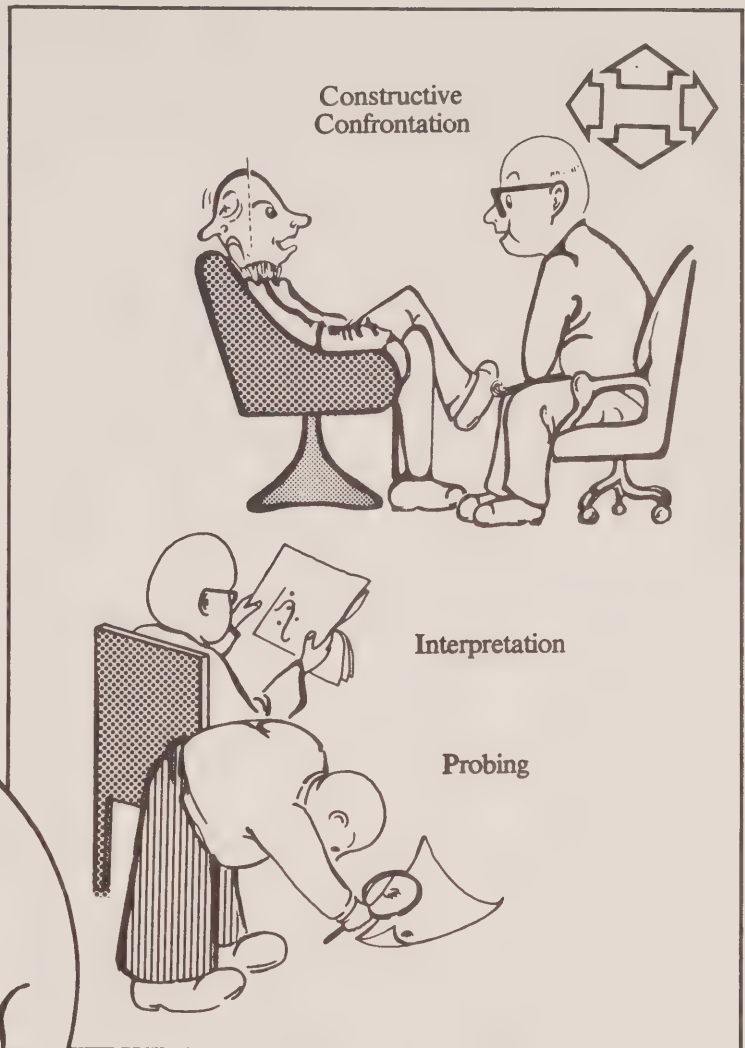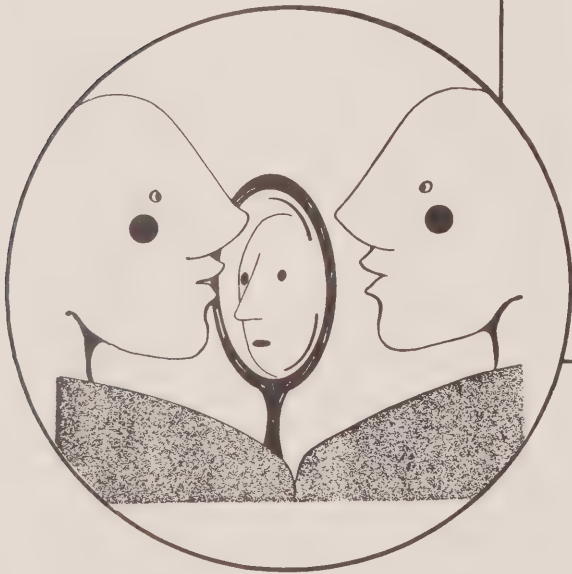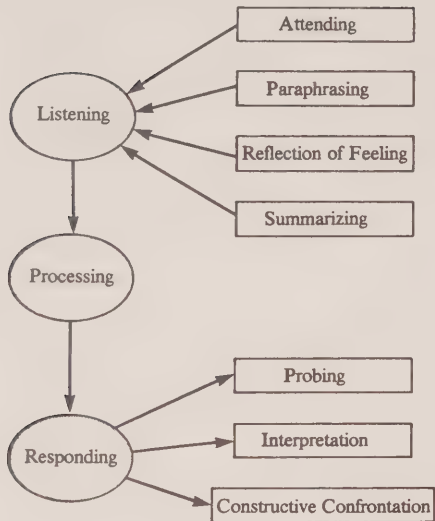
Module 4: OBSERVATIONS AND CONCLUSIONS

OVERVIEW OF MODULE 4 –
OBSERVATIONS AND CONCLUSIONS

Time required	30 – 45 minutes
Format	Large group
Supportive materials	– Flipchart/blackboard – felt pens/chalk
Learning objective	At the conclusion of this module, participants should have a working knowledge of reflective and directive skills and should feel a sense of closure on the events of the day.

ACTIVITY A

OBSERVATIONS AND CONCLUSIONS

Time required	30 – 45 minutes
Format	Large group discussion
Supportive materials	– Flipchart/blackboard – felt pens/chalk
Learning objective	To ensure that participants understand and can begin to use reflective and directive skills in their work.

In the large group format, the trainer will begin this concluding segment by taking up the practice exercise that participants have completed in their Participant's Manual, pages I-37 to I-38. This exercise is used as a catalyst for participants and group leaders to discuss the material of Unit I. The trainer should encourage discussion of both the process of the day and the content in order to make adjustments to subsequent presentations of this material. In taking up the written exercise, participants should be encouraged to talk about their small group practice experience.

The trainer should move the discussion from the practice exercise, through specific questions about the seven skills, to a general discussion of how participants can benefit from using the skills in their daily work.

Upon conclusion of the discussion, the trainer should remind participants of any housekeeping items e.g. additional reading; the time and date of the next training session, and conclude the day.

(See pages I-37 to I-38 of Participant's Manual)

REFERENCES

National Center for Alcohol Education. *Counselling Alcoholic Clients.* Rockville, Maryland: National Institute on Alcohol Abuse and Alcoholism, 1982.

APPENDIX A

SKILL CATEGORY CARDS REFLECTIVE COUNSELLING SKILLS

ATTENDING

(see Participant's Manual)

(Page I-13 to I-15)

PARAPHRASING

(See Participant's Manual)

(Page I-16 to I-18)

**REFLECTION
OF FEELING**

(see Participant's Manual)

(Page I-18 to I-21)

SUMMARIZING

(See Participant's Manual)

(Page I-22 to I-24)

APPENDIX B

REFLECTIVE SKILLS EXERCISE*
(VERSIONS A AND B)

Client: I don't know what's happening, but whatever it is, I don't like it.

Counsellor: Sounds like things are still not going all that well for you; tell me more about what is happening.

Client: No – things are awful (teary-eyed)....in spite of two months of treatment, I'm still drinking, my wife and I are at each other's throats all the time, and nothing has changed at work.

Counsellor: ....

Client: I can't believe how well everything is going.

Counsellor: It's good to see you smiling. What has changed since coming to the treatment centre four weeks ago?

Client: Well – I can't believe after drinking for 17 years that I can be cured so fast....this is really great! I'm ready to take on the world!

Counsellor: ....

Client: It's hopeless....it's just not worth the effort....

Counsellor: What's happened to make you feel this way, Lynn?

Client: Since I've quit drinking, my family has been just awful. My kids keep telling me to quit bugging them....and all I'm doing is showing an interest in them. And my husband seems to resent anything I do ....all he does is criticize. Things were better when I was drinking!

Counsellor: ....

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*Photocopy pages I-42 to I-46 and distribute to students.

Client:	Things are really getting ridiculous!
Counsellor:	What is getting ridiculous?
Client:	The people at work: the boss and the line supervisor. They've got to realize that I need more time to learn the job. I've only been there two months.
Counsellor:	Things don't sound too good at work – can you tell me more?
Client:	They expect too much. I have three different jobs to do on the line, and no one bothered to show me how to do them. I think the company is in trouble and these two are getting heat from upstairs so they are tightening the screws on the guys on the line – I'm going to show them, I'll quit!
Counsellor:	………..

Client:	The judge sent me so I'm here! (Spoken in a loud voice and very aggressive)
Counsellor:	Could you tell me more about how the judge came to send you here?
Client:	Yea – he said I've got a drinking problem and part of my sentence it to get treatment. This is a waste of my time – I'm no alcoholic!
Counsellor:	Could you tell me why the judge thinks you have a problem?
Client:	It's just bad luck. Everybody drinks and drives but I always get caught. I have two impaired driving convictions and they say I tried to hit the cop who stopped me the last time. I don't even remember anything about the incident…and they say they're going to charge me with assaulting an officer.
Counsellor:	………

Client:	I don't know what to do….Children's Aid is coming tomorrow and I just know they will take Johnny away again….And the welfare has refused to give me more money because they say I drink too much…. The welfare worker came on a day when a friend was over and we were celebrating his birthday. Life is such a mess….I got kicked out of my old place cause they said I made too much noise….Have you ever tried to keep five kids quiet?….And I quit the course at Manpower because they said I was drunk….Can you help me? – I just don't know where to turn.
Counsellor:	……..

Counsellor:	How have things been going with you and your roommate?
Client:	I kicked her out! If I ever see her again I think I'll kill her!
Counsellor:	Oh?
Client:	Last week I got home from work early, and guess who was fooling around with my boyfriend? She has some nerve! It looked to me like they were drinking all afternoon....and here he was trying to sneak out the back door when I came in the front.
Counsellor:	....

Client:	Well, marijuana is better than booze, isn't it? No hangovers, you don't get addicted – it's got to be better!
Counsellor:	Tell me more about your switch from booze to marijuana.
Client:	After our last session, I agreed with you. Booze is causing a lot of problems for me. So, I decided to quit drinking and smoke a little more dope instead. I won't have liver problems, no more hassles with breathalyzer tests, and I can grow my own each summer, so it will be cheaper.
Counsellor:	I see....
Client:	Yea, the only problem is that my friend got busted last week for growing dope and they might suspect me too – I hid all mine outside so I can't be charged with possession, but I'm not sure.
Counsellor:	....

Client:	I'm fed up with this treatment. Nothing ever happens....all you do is sit there and smile! What's the matter with you anyway?
Counsellor:	Um hum.
Client:	See, there you go again. What are you doing to stop my drinking? Since coming here, I haven't even started to stop.
Counsellor:	....

Counsellor:	Tell me more about how you and your father are getting along now.
Client:	Nothing has changed. He still treats me like a kid! Sometimes I get really frustrated with him.
Counsellor:	Oh?
Client:	Yea, he always tells me these crazy stories about the war and when I try to get him to change the subject, he accuses me of not caring about him. I try to explain, but he won't listen and we just get into arguments and he tells me about every rotten thing I did as a kid and I tell him that he drove mom to drink. Then we don't speak to each other for days and I usually start to drink again cause I feel so guilty.
Counsellor:	. . . .

Client:	I just walked into his office and told him where to go....never felt better!
Counsellor:	You mean you quit your job? Tell me more.
Client:	Yea I quit, I wasn't going to take any more insults about my work.....if they don't like the way I do things then tough....I'll tell you, I sure tied one on when I left the plant. I was so mad when I left, I stayed drunk for two days.
Counsellor:	. . . .

Client:	Everything is fine with the drinking, but I'm really worried about my husband.
Counsellor:	Oh?
Client:	Yea – Since I stopped drinking four months ago, he has become more argumentative and sulky. He still won't let me use the car alone – he thinks I may start drinking again. And what's more, he has started to have five or six drinks every evening. I really don't know what to do.
Counsellor:	What would you like to do?
Client:	Well, I want him to come for therapy as well, but he gets really angry whenever I raise the subject. He doesn't think that he has a problem and whenever we try to talk about it, he just brings up my past and says that "time will tell".
Counsellor:	. . . .

Client:	I just had to see you today.
Counsellor:	Oh?
Client:	Yes, John has started drinking again. He started drinking yesterday after work and kept on drinking all evening. He was really abusive and even threatened to hit one of the kids. Last night around 10:00 he went out and I haven't seen him since. I just don't know what to do – I called his work and pretended to be a friend – so they wouldn't know that anything happened at home, eh.... They said that he hadn't come in to work today and they hadn't heard from him.
Counsellor:	....

Client:	I just don't understand the kid. We have done everything for her....and she goes and does this again. I've had it.
Counsellor:	Tell me what has happened.
Client:	Sandra went out with that "crowd" again and she didn't come home until 11:00 the next morning. It just isn't right for a 16-year-old to be hanging around with those 24-year-olds. For all I know she's pregnant! – seems to me our only choices are to lock her up or kick her out!
Counsellor:	....

Client:	My parents just don't trust me....I don't know what to do.
Counsellor:	What makes you think they don't trust you?
Client:	They don't believe what I say. I was out two nights ago with some people and this guy's car broke down. We hitchhiked to my girlfriend's and it was really late – like 2:00 a.m. so I slept there and tried to call home in the morning, but everyone was gone to work. Well, when I got home, I was accused of "sleeping around" and drinking and doing drugs. It's all a lie, but my parents won't listen. They won't even phone my girlfriend's parents to prove that I'm not lying. Now they are saying I can't go out again – ever! I just don't know what to do.
Counsellor:	....

APPENDIX C

FORMING GROUPS

Forming Groups for Exercises and Practice Sessions

Many program activities are conducted in groups of varying sizes. Whatever the numbers are in each practice session group, a basic tenet to keep in mind is that the procedure for dividing a large group into smaller groups must be simple, lead to a minimum of confusion, and guide participants into the correct grouping quickly.

The most common grouping used for practice sessions is the triad. This provides two actors and one recorder/observer. For the purposes of this particular Unit, groups of four, five, or six are workable and have some added benefit over the triad. With more than one observer, additional feedback can be elicited allowing for a variety of perspectives to be discussed. In addition, the more actors that play counsellor roles, the more the variation in skill demonstration. Having four to six participants also encourages more discussion of fine points in the use of skills.

If you wish to have groups of four, begin by numbering the participants. This can be done by numbering chairs (from one to four), table positions, or participant handbooks, or simply by numbering off the participants themselves. If some people are left over, assign each to a different group. Ensure that groups with one extra person in them do slightly shorter individual practice sessions to ensure that all groups finish at approximately the same time. This can be accomplished by either shortening the practice sessions for those groups or lengthening them for the other groups with fewer members. Assign each grouping a letter (A, B, C, D, etc.), so that groups may be assigned to specific rooms (e.g. group A to Room X).

APPENDIX D

FEEDBACK AND ASSUMPTIONS

Feedback

During skill practice sessions, participants will take turns as counsellor, client and observer. The client and observers will give the counsellor feedback dealing with his or her performance of the skill in question.

The definition of feedback as used in the context of the practice sessions is: telling the counsellor what you (as observer) heard and saw as he/she practised a particular skill, or what you (as client) felt in response to his/her practice of the skill.

The extent to which you give each other feedback and the quality of the feedback may be the critical factor in determining whether or not this training will be productive for you. For example, if in practice sessions neither the observers nor the clients give you significant feedback about your performance as a counsellor, you might complete your training, having gone through all the prescribed activities, and have gained little. You may perhaps even take away a more distorted rather than a clearer picture of your capabilities. In addition, being a recipient of feedback can help sharpen your perception of what constitutes useful feedback.

When giving feedback, whether positive or negative, keep these guidelines in mind. They apply to both counselling and skill practice situations.

- The purpose of feedback is to be helpful to other people by giving them useful information about what they are doing or the effect they are having on you.

- Timing is important. If feedback is given so long after a happening that the recipient can't remember the happening clearly, it is not likely to be helpful. Feedback is most helpful when given as soon as possible.

- Be specific rather than general. Generalities often raise people's defences so that they don't get the message you are trying to give. It's much easier to hear and acknowledge "I felt annoyed when you were late for our appointment today," than it is to hear and acknowledge "You're always late and I'm sick and tired of it." (Even if the other person is always late and you are sick and tired of it, it's more constructive to deal with specific situations as soon as possible, rather than not give feedback and sit on your feelings until you finally explode.)

- Being descriptive rather than judgmental is also less likely to raise people's defences and is more helpful. "You just went through a stop light and you're driving at 40 mph in a 20 mph school zone, and I feel nervous," is more constructive than "You're really a lousy driver."

- The last point to remember about feedback is that it should be directed toward behaviour about which the receiver can do something. While you may find you simply have to tell someone the effect that his/her height, or age, or colour of eyes has on you, this is not feedback. In effect, you're not telling that person anything about himself/herself but something about yourself. Even if it's positive, such as "Darling, I just love your green eyes," you're talking about your own likes or dislikes rather than something someone else has control over and could change if he/she wanted to.

Assumptions

Despite earnest intentions to give accurate and meaningful feedback, we may sometimes unconsciously erect barriers to doing so. These barriers may derive from our own needs, beliefs, prejudices, preferences, values, or fears, and they may frequently take the form of assumptions about others. Sometimes our assumptions are on target; quite often they are far from reality. However, they are accurate often enough to encourage us to keep making assumptions.

Making assumptions often takes the form of taking observable facts about another person, developing a theory to explain those facts, and then treating the other person as if your theory is proven. In alcoholism counselling, this process might mean observing that a client's eyes are bloodshot, assuming that he/she has been drinking, and reacting to the client with anger and disappointment on the basis of your assumptions. The client, however, may actually have hay fever or may not have been able to sleep. This kind of assuming is sometimes called pigeon-holing or stereotyping.

Making assumptions can also take the form of making another person responsible for our feelings. For example, I may feel frightened; if I assume that some other person is threatening to me, then this assumption justifies or rationalizes my fear. This process could easily take place with a client who may, in reality, be dangerous only to himself/herself or not dangerous at all.

Three things to remember about assumptions are:

— **Recognize** that you probably have some.

— **Don't take them too seriously.** You can't know another person's experience, only your own perceptions of that experience. Any conclusions or theories that you may have about another may be accurate or they may be only your assumptions. Suspend judgment about the meaning of your observations until you verify the facts (below).

— **Check them out.** Using nonjudgmental words and tentative phrases, share your assumptions with the recipient and see whether they are accurate or not (e.g. "It seems like you may have been drinking today.") Remember, the object in counselling another is not for the counsellor to be right (and the client wrong) but rather to establish communication, build a relationship, and help the client develop the capacity to deal more effectively with his/her life.

False assumptions are usually rooted in negative (unconstructive attitudes), which will be further discussed in Unit III, regarding the initial interview.

APPENDIX E

COUNSELLOR RESPONSE RECORDING FORM

Opposite each number below, please label each skill that the counsellor is using on the videotape, using the terminology of this program.

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

11.

12.

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14.

15.

APPENDIX F

PRACTICE EXERCISE – REFLECTIVE AND DIRECTIVE
COUNSELLING SKILLS

Client: I'm so upset this morning that I can't even think. You just wouldn't believe what my father has done.

Counsellor: Could you tell me a little more about it? **(PROBING)**

Client: Well, you know my mother just died a few months ago, poor little thing, she was so afraid of dying, and she was sick for so long. We all did everything that we could for her and I thought Daddy loved her and cherished her memory. It was just awful. I had a telephone call from this friend of mine last night and she said, "Do you know where I saw your daddy last night?" He was at a bar with this woman – I know her and I can't wait to get back to her and tell her what I think of her.

Counsellor: You seem to feel pretty displeased with your dad's behaviour. **(REFLECTION OF FEELING)**

Client: I sure am. I mean the flowers haven't even wilted on Mother's grave and he's out catting around. We moved in to help take care of him – but I'm moving out tomorrow. I told him so. He came in this morning looking like a sheep dog and I really let him have it.

Counsellor: You moved in to take care of your dad, but have you considered that maybe he's lonely and needs some companionship after losing your mother. **(INTERPRETING – COUNSELLOR PROVIDES INTERPRETATION)**

Client: Well, that may be, but that doesn't explain why he wasn't all that good to mother while she was alive. He used to play poker, or so he said. I'm not sure what he was doing. But Mama would call me and – I didn't have a car because George was always gone to some beer joint in it – but poor Mama would cry and say how lonely she was and I knew she was sick and afraid and there was nothing I could do.

Counsellor: So you were dealing with two problems – your mother's poor health and loneliness and your husband's drinking. **(PARAPHRASING)**

Client: Yeah, but Mama's sickness bothered me more than George's carousing and drinking. You know, when Mother was in the hospital this last time Dad never left her – it just doesn't fit together for him to act like this. There was never a better woman than my mother – he could at least have waited.

Counsellor: Sounds like you loved and admired your mother a great deal. **(REFLECTION OF FEELING)**

Client: I did. She was so good to me and I felt so horrible and helpless when she died. I just feel like I've got all these responsibilities now and I don't know if I can handle them. That's why I get so mad when I think my Dad isn't helping me.

Counsellor: You feel weighted down by many problems and resentful that no one is helping you face them, is that it? **(REFLECTION OF FEELING)**

Client: Yeah, I do. I mean there's my little brother still at home, and he's in jail for drunk driving and where's that going to leave him with no mother, and a daddy who runs around and drinks and lets him have all the money he wants and the car and a credit card. And then he keeps saying he doesn't know what to do

with the boy. Mama would turn over in her grave if she knew he was in jail. And George has that drunk driving charge against him from the accident, and you know, he's out of work. I just don't know if I can keep going on.

Counsellor: At this point, it looks like you're going through a lot emotionally. You're feeling hurt about your mother's death, frustrated about your husband's drinking, discouraged about your brother's actions, and angry at your dad's behaviour. **(SUMMARIZING)**

Client: Yeah, that about covers it, but left out how mad I am at that woman. She knows how we all feel about her – when I get through with her she won't know what hit her. The others, they won't do anything, but I will. I may be the youngest, but I can hang in there whenever I get mad, and I was so mad. I really gave Dad a tongue lashing I'll never forget and he won't either. I told him I was ashamed of him and I'd never forgive him and he could just find someone else to wash his clothes and fix his meals.

Counsellor: You know, so far you have told me how upset you are about your mother's death and how angry you are at your father; how do you think your father feels about your mother's dying? **(INTERPRETATION – COUNSELLOR DIRECTS CLIENT TO GENERATE THE INTERPRETATION)**

Client: Well....I guess it really hurt; just to sit and watch her dying and not being able to do anything about it. Yeah – it really did hurt, he cried when Mama got so bad that she couldn't get out of bed. He said he could't stand to see her that way, he was really broken up after that....(pause)....I guess that could make you do some pretty crazy things, eh?

Counsellor: Well, what do you think? **(PROBING)**

Client: Yeah, I guess it's made me do some pretty crazy things....What do you think I should do?

Counsellor: Well, on the one hand, you seem to be condemning your father as the culprit, but on the other hand you are saying that, with all this stress, you have done some pretty crazy things too. **(CONSTRUCTIVE CONFRONTATION)**

Client: Yeah, I see what you mean – I guess one of my crazy things was all the yelling, eh?

Counsellor: Perhaps, but let's go back to how your father might feel for a minute longer – ok? You said earlier that you were angry because you felt that your Dad wasn't helping you. How do you think your Dad feels about how you have helped him since your Mom died? **(INTERPRETING – COUNSELLOR DIRECTS CLIENT TO PROVIDE INTERPRETATION)**

Client: Well....I moved in to help him and I know he appreciated it, but then he took off with this other woman....(pause)....I guess my shouting and yelling and creating a fuss didn't help Dad or me – he was really upset – he didn't even say anything, just sort of stood there looking pathetic. I'm so confused.... (pause).... I really hate that woman!

Counsellor: Can you tell me more about your hate? **(PROBING)**

Client: Well, Daddy isn't the first man she's gone after, you know. She tried to pick up George once.

Counsellor: Ah. **(ATTENDING)**

Client: I mean he wouldn't have anything to do with her, but she tried and she's just not above anything. She even called the house once. This whole thing is her fault!

PRACTICAL
DRUG CONCEPTS

UNIT II
PRACTICAL DRUG CONCEPTS – TRAINER'S MANUAL

TABLE OF CONTENTS

INTRODUCTORY PERSPECTIVE

Practical knowledge concerning *drugs* and *drug-use consequences* is essential to help form the content of face-to-face counselling communications. This kind of knowledge helps the counsellor decide what questions to ask as well as assess immediate hazards and probable risk levels of a client's drug use.

Accurate knowledge about drugs also gives the counsellor confidence in the interview process, and helps with answering clients' questions about drug use and the interview structure.

The trainer should be selective in terms of what material is emphasized. Not all of it can be adequately covered in the time allowed. However, the Participant's Manual should be seen as a source book for trainees to keep for reference and review.

The trainer should be an experienced physician, clinical pharmacologist or pharmacist, with lecture skills, in view of the technical nature of the content.

The content presented is intended to provide participants with a practical understanding and tools for applying specialized knowledge of drugs, drug use, and drug effects in initial screening, assessment, and treatment planning. Note, however, that the Unit does *not* purport to provide comprehensive knowledge of pharmacology.

Prior to teaching this material, the trainer (or the trainer, along with the expert resource person involved) should review those parts of the Unit which are to be used. A sample schedule is provided on pages II-8 to II-9 to assist in organizing times designated for each learning activity.

The warm-up exercises can be conducted by a trainer who is not qualified as is suggested in paragraph four above. However, lectures on drugs, hazards, and risk indicators are to be done by qualified specialists in these areas.

Exercises described in APPENDICES A, B and D are optional. Some or all of these exercises may be used as pre-course learning activities. Depending upon time and participant limitations they also may be used as homework or small group work during the course.

Appendices A, B and C, may either be used as pre-course exercises, or as assignments during the conduct of the course. Trainers are encouraged, as in other parts of this program, to design additional exercises which allow participants to work with the content.

Before beginning this Unit, trainers must ensure that they have completed the following three preparatory steps:

1) The trainer should have read the training manual and accompanying appendices thoroughly to ensure a sound understanding of content.

2) The trainer should have a "dry run" with all materials, instructions and exercises that they are not absolutely familiar with. This will ensure that trainers fully understand the training methodology.

3) The trainer should gather all materials and equipment beforehand and test them to ensure a smooth flowing training session. This is particularly critical with regard to audiovisual equipment to ensure knowledge of operation and compatibility of videotapes with playback units.

A sample schedule for this Unit has been included on pages II-8 to II-9. If trainers choose to use this schedule, they must send out Participant's Manuals well ahead of the training event. (It may be advisable to telephone each participant about one week prior to the event to ensure that they have received the material and to explain again to them how important it is to read it.)

If the trainer wishes to expand the time-frame for this Unit, time could be allowed for segments of the manual to be handed out and read during the session time.

A final comment relates to the structure of the Unit. It has been constructed so that it may be used as a whole, or modules may be independently selected for use on their own.

OBJECTIVES

PRACTICAL DRUG CONCEPTS
MODULE 1: DRUGS

Goals/Objectives

The goal of this module is to familiarize participants with major classes of drugs.

By the end of this module, participants will be able to identify:

- the scientific definition of a "drug";
- the meaning of major pharmacological terms (tolerance, dependence, synergism, cross-tolerance);
- major classes of drugs (opioid, analgesics, general depressants, stimulants, hallucinogens, cannabis).

MODULE 2: HAZARDS

Goals/Objectives

The goal of this module is to equip participants with concepts and tools for assessing gross risks associated with the use of some common drugs.

By the end of this module, participants will be able to:

- list the "criteria for drug use hazard potential".

MODULE 3: RISK INDICATORS

Goals/Objectives

The goal of this module is to describe a screening model for estimating drug use risks for purposes of assessment, treatment planning, and making decisions for referral.

By the end of this module, participants will be able to describe and discuss:

- six categories of gross risk indicators (physical, drug dose, employment/ financial, marital/family, legal, leisure);
- use of the alcohol "risk-o-graph" in simulated assessment cases.

MODULE 4: CASE APPLICATIONS

Goals/Objectives

The goal of this module is to bring closure to the Practical Drug Concepts Unit and begin to integrate these concepts with counselling communication skills and issues of initial assessment interviews. By the end of this module participants should be able to discuss how the special hazards and risks associated with drug use relate to the counselling interview process in terms of acute and chronic effects.

SAMPLE SCHEDULE
UNIT II: PRACTICAL DRUG CONCEPTS

SAMPLE TIMES	TIME REQUIRED	TITLE	ACTIVITY/ FORMAT	MATERIALS	PAGE
9:00	25 min.	**Module 1** Drugs	Activity A – Warm-up exercise – Large group	– Flipchart/blackboard – chalk/felt pens – masking tape	II-13 to II-14
9:30	20 min.		Activity B – What is a Drug – Small group exercise	– Small group discussion areas – copies (one for each participant) of CLASSIFICATION SHEET, "What is a Drug"	II-14 to II-16
9:50	30 min.		Activity C – Pharmacological Terms – Lecture, – Large group	– Flipchart/blackboard – chalk/felt pens	II-17
10:20	30 min.		Activity D – Drug Groups – Lecture – Large group	(Same as above)	II-17 to II-18
10:50	10 min.	BREAK			
11:00	60 min.		Activity D – (continued)	(Same as above)	
12:00	60 min.	LUNCH			
1:00	20 min.	**Module 2** Hazards	Activity A – Criteria – Large group – Lecture – Discussion	– Flipchart/blackboard – chalk/felt pens	II-21 to II-22

SAMPLE SCHEDULE

UNIT II: PRACTICAL DRUG CONCEPTS
(Continued)

SAMPLE TIMES	TIME REQUIRED	TITLE	ACTIVITY/ FORMAT	MATERIALS	PAGE
1:20	40 min.		Activity B – Medical Consequences of Alcohol Abuse – Large group – Lecture – Discussion	– Flipchart/blackboard – chalk/felt pens	II-22 to II-23
2:00	30 min.	**Module 3** Risk Indicators	Activity A – Risk Estimates and Categories – Large group – Lecture – Discussion	– Flipchart/blackboard – chalk/felt pens	II-27 to II-31
2:30	15 min.	BREAK			
2:45	30 min.		Activity B – Risk-o-graph – Large group – Exercise – Discussion	– Risk-o-graph	II-31 to II-32
3:15	60 min.	**Module 4** Case Appli-cations	Activity A – Drug Interaction Effects – Large group – Discussion	– Flipchart/blackboard – chalk/felt pens – "Drug Risk Checklist"	II-35 to II-37
4:15	45 min.		Activity B – Conclusion – Large group	– Flipchart/blackboard – chalk/felt pens	II-38 to II-39
5:00		ADJOURN			

Module 1: DRUGS

IDENTIFY: Scientific definition
Pharmacological terms
Classes of drugs
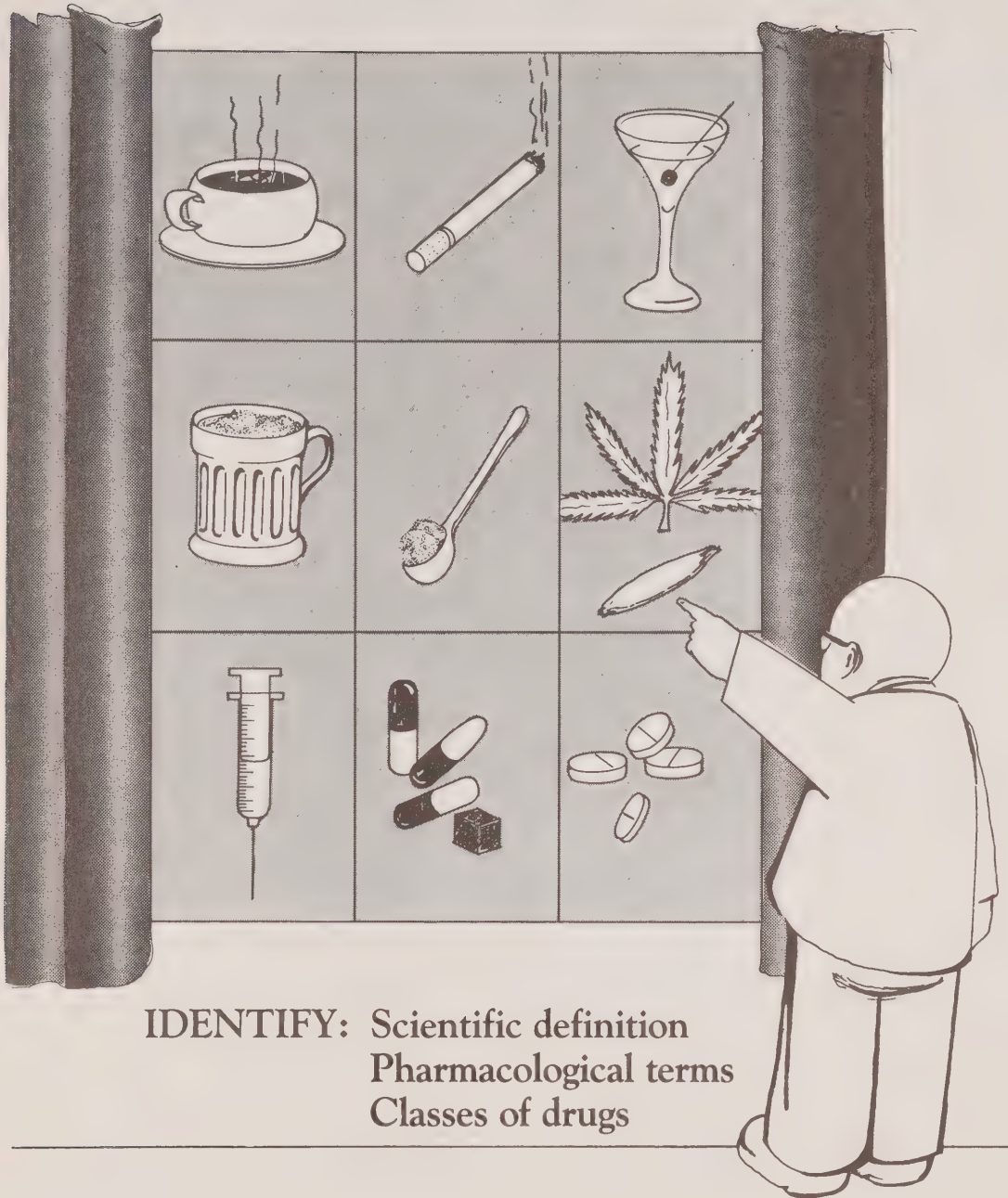
Module 1: DRUGS

OVERVIEW OF MODULE 1: DRUGS

Time required   165 minutes (2 hours 45 minutes)

Format   Large group
– lecturette
– exercise
– discussion.

Supportive materials   – Flipchart/blackboard.
– felt pens/chalk.

Learning objectives   Ensure that participants:

1) understand the scientific definition of "drug";

2) can define major pharmacological terms;

3) can identify the major classes of drugs.

Trainer qualifications   Clinical pharmacologist, clinical pharmacist, and/or physician with experience in the management of drug dependence.

ACTIVITY A

WARM-UP

Time required   25 minutes

Format   Large group
– Discussion and lecturette

Supportive materials   – Flipchart/blackboard
– chalk/felt pens

Learning objectives   1. To enable participants to describe the importance of accurate definitions and perceptions of key drug concepts.

2. To enable participants to answer questions addressed by this Unit.

Instructions For Training Activity A

Total Group Warm-Up Exercise

Definitions and Perceptions

Tell the group that the following exercise will aid in illustrating definition and perception difficulties relating to the terms, drug abuse and drug addict. Remind the group that the way problems are defined and perceived often causes as many difficulties as the problems themselves.

Tape three sheets of newsprint to the front wall. At the top of the first sheet write the word DRUG; at the top of the second sheet write the words DRUG ABUSE; at the top of the third sheet write the word ADDICT.

Ask participants to define the term DRUG. Record their responses on the newsprint.

Ask participants to define the term DRUG ABUSE. Record their responses on the newsprint.

Ask participants to describe, with one word, their perception of an ADDICT. Record their responses on the newsprint.

ACTIVITY B

WHAT IS A DRUG?

Time required	20 minutes
Format	Small group – Large group discussion
Supportive materials	– Handout – "What is a Drug"?
Learning objectives	Ensure that participants: 1. can write their own working definition for the term drug. 2. are aware that many frequently used terms in the drug abuse literature have different meanings.

Instructions For Training Activity B

1. (First 10 minutes) Assign participants to small groups of 3 to 7 each. Hand out "What is a Drug?" (APPENDIX E, p. II-53)

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*If it is impossible to distribute this exercise prior to the course it may be used at the beginning of the program.

2. Reconvene the large group and guide the following discussion:

Ascertain how many participants placed each substance in the "drug" category and how many did not. The trainer can expect considerable differences in opinion about many of them. This disagreement should be used to illustrate that the meaning of such a commonly used term as "drug" is ambiguous.

Ask the participants for elements of their working definition. Try to extract the following:

— a drug is a substance administered with the *intention* of producing a *desired* change in normal *body function* (psychological, physiological, biochemical, etc.). The definition usually excludes foods and other components of a normal diet;

— a substance is categorized as a drug based on *why it is used* rather than on *what it is*;

— substances are considered drugs when used for some purposes, but not when used for others. For example, normal components of our diet, e.g., salt, sugar and vitamin C would not normally be thought of as drugs. On the other hand, they are definitely considered drugs when used in pure form in the treatment of certain medical problems. Coffee would be considered part of our normal diet. Decaffeinated brands are consumed presumably for their taste and do not serve as drugs. Many drinkers of coffee containing caffeine, however, are intending to achieve a specific change in alertness and mood state. In this case, caffeine is definitely functioning as a drug;

— drugs can be used for either therapeutic or non-medical reasons. With medical agents, (e.g., tetracycline or other antibiotics), there is rarely . disagreement about the desirability of the effects. In some cases, non-medically used substances can produce effects desirable to the *user* (e.g., intoxication) that would be considered undesirable by the user's parents, teachers or physician. Where there is disagreement about the desirability of the effect, the user's perspective is considered most important;

— insecticides (DDT), herbicides (paraquat), for example, that produce undesirable effects in humans would normally be labelled toxins or poisons rather than drugs. Only in the situation where a toxic effect is desired by the user (e.g., a suicide attempt) would one of these substances be considered a drug.

(See pages II-8 to II-9 in Participant's Manual)

TRAINER'S NOTES

Review the following at the conclusion of this exercise:

— Discussions of drugs and drug effects abound in ill-defined terms, imprecise concepts, and over-generalizations. Even when the same words are used and the illusion of communication exists, non-communication and controversy are often the reality. Necessary discriminations are not made, assumptions are not examined, stereotypes are invoked consciously or unconsciously, fact is not distinguished from opinion and feeling;

— Effective treatment planning depends importantly upon clear definitions, perceptions, and assessment of the drug problem;

— One and the same substance may be referred to as psychoactive, psychotomimetic, psychodysleptic, psychedelic, dangerous, dependence-producing, hallucinogenic, even narcotic – all with little regard for its basic pharmacological actions;

— Each term carries with it a halo of feeling, belief, expectation, and judgment that goes beyond the specifics and pharmacological action. Each term attributes to the substance itself characteristics that more properly belong to the interaction among substance, person, and context;

— Discuss correct answers to pre-course assignment/exercise (APPENDIX E) if used.

Point out that common questions asked by those who come into professional contact with alcohol-dependent and other drug-dependent clients are:

1) What is a drug?

2) What drugs are similar in action?

3) How can the dangers of various kinds of drug use be determined?

4) How much is too much for safety?

5) How can risks of various drug use patterns be estimated?

6) What combinations of drugs are dangerous and what are the dangers?

7) What does a counsellor need to know about drugs and drug use when counselling clients who have drug related problems?

This Unit is designed to provide introductory answers to these questions.

(See pages II-9 to II-13 in Participant's Manual)

ACTIVITY C

PHARMACOLOGICAL TERMS

Time required	30 minutes
Format	Large group Lecturette and Discussion
Supportive materials	– Flipchart/blackboard – chalk/felt pens
Learning objective	To enable participants to define tolerance, dependence, synergism, cross-tolerance and withdrawal.

Instructions For Training Activity C

Present a lecturette covering the following topics:

1. Drugs: review definition.

2. Drug effects: doses, variability of effects, synergism.

3. Tolerance and cross-tolerance.

4. Dependence.

5. Withdrawal.

The trainer should stress the relationship between these concepts and key aspects of assessment for treatment planning, sequence of treatment interventions and relapse prevention/response. Particular emphasis should be placed on high medical risk drugs, doses, interactions, dependence and withdrawal situations.

ACTIVITY D

DRUG GROUPS

Time required	90 minutes
Format	Large group lecturettes and discussions
Supportive materials	– Flipchart/blackboard – chalk/felt pens

Learning objective

To enable participants to classify drugs according to
• Opioid analgesics;
• general depressants
• stimulants;
• hallucinogens/cannabis, etc.

Instructions For Training Activity D

Present a series of lecturettes covering the following drug groups. Allow for some discussion following each topic to allow for clarifying and other questions about *effects*, *tolerance* and *dependence*.

1. Opioid Analgesics, including:

   Natural opioids;
   semisynthetic opioids;
   synthetic opioids;
   narcotic antagonists.

2. General Depressants, including:

   barbiturates;
   benzodiazepines.

3. Inhalants (solvents and aerosols):

   volatile hydrocarbons

4. Alcohol:

   short-term effects;
   long-term effects;
   medical consequences;
   social-psychological consequences.

5. Stimulants:

   amphetamines and related stimulants;
   cocaine;
   caffeine;
   nicotine.

6. Psychedelics (hallucinogens):

   cannabis (marijuana, hashish, etc.);
   LSD;
   PCP.

(See pages II-14 to II-37 in Participant's Manual)

Module 2: HAZARDS
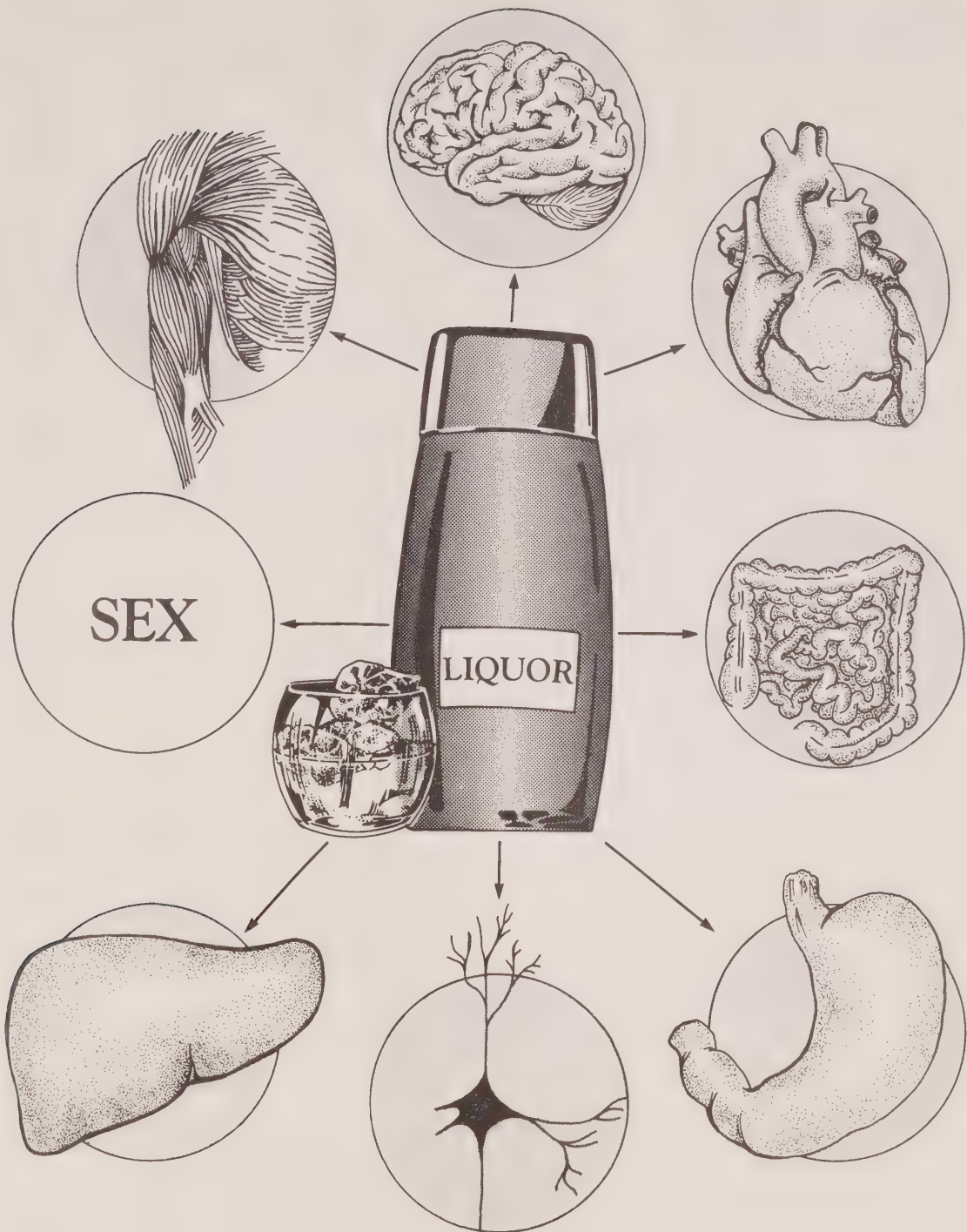
LIST: Criteria for drug use hazard potential

Module 2: HAZARDS

OVERVIEW OF MODULE 2: HAZARDS

Time required	60 minutes
Format	Large group – lecturette – discussion.
Supportive materials	– Flipchart/blackboard. – felt pens/chalk
Learning objective	Ensure that participants: 1) Can list global criteria for drug use hazard potential.
Trainer qualifications	Clinical pharmacologist, clinical pharmacist and/or physician with experience in the management of drug dependence.

ACTIVITY A

CRITERIA

|	
Time required	20 minutes
Format	Large group lecturette and discussion
Supportive materials	– Flipchart/blackboard – chalk/felt pens
Learning objective	To enable participants to list the eight global criteria for drug use hazard potential.

Instructions For Training Activity A

Present a series of lecturettes covering the following factors related to drug use. Allow for some discussion following each topic to clarify and answer questions about *how risk increases* with respect to these factors.

Key Points

Hazards increase in relation to the following factors, or global criteria for drug use hazard potential.

1. Frequency of use (repeated/compulsive);

2. Route (e.g., oral versus intravenous);

3. Manner used (self-destructive);

4. Risk of physical dependence;

5. Degree of impaired judgment;

6. Risk of social deterioration;

7. Risk of tissue damage and disease;

8. Risk of death from overdose.

The trainer should give brief case examples of each of the above from his/her experience and/or ask participants to give examples to make these criteria relevant to the trainees' work situation.

(See page II-41 in Participant's Manual)

ACTIVITY B

MEDICAL CONSEQUENCES

Time required	40 minutes
Format	Large group lecturette and discussion
Supportive materials	– Flipchart/blackboard – chalk/felt pens
Learning objective	To enable participants to identify objective medical hazards associated with major systems, focusing on alcohol abuse.

Instructions For Training Activity B

Present a lecture covering the following key points briefly and referring to Participant's Manual for further detail.

The purpose of this lecture is to alert participants to the wide- ranging correlates of alcohol abuse specifically and drug abuse generally, stressing the importance of drug interactions.

Key Points

1. **Alcohol and brain damage –**

   Some after effects; brain atrophy, Wernicke-Korsakoff syndrome, chronic subdural haematoma; portal systemic encephalopathy.

2.   **Alcohol and the stomach –**

Gastritis; peptic ulcer and alcohol.

3.   **Alcohol and the pancreas –**

pancreatitis

4.   **Alcohol and the intestines –**

enteritis

5.   **Alcohol and the liver –**

fatty liver; alcoholic hepatitis; alcoholic cirrhosis; complications of cirrhosis

6.   **Alcohol and the heart –**

cardiac arrhythmias; coronary artery disease; alcoholic cardiomyopathy

7.   **Alcohol and blood pressure –**

essential hypertension

8.   **Alcohol and the nerves of the body –**

alcoholic-nutritional neuropathy

9.   **Alcohol and the muscles –**

alcoholic myopathy

10.   **Alcohol and infection –**

impaired resistance to infection; infections in the lungs-pneumonia

11.   **Alcohol and cancer**

12.   **Alcohol and sexual dysfunction**

13.   **The foetal alcohol syndrome (FAS)**

14.   **Alcohol and sleep disturbances**

15.   **Interaction of alcohol with medications –**

sedatives, hypnotics and antihistamines and alcohol; major tranquillizers and alcohol; antidepressants and alcohol; salicylates and alcohol; alcohol and diabetes treatment; alcohol and anticoagulants; alcohol and anticonvulsants (see APPENDIX A, in Participant's Manual).

Module 3: RISK INDICATORS
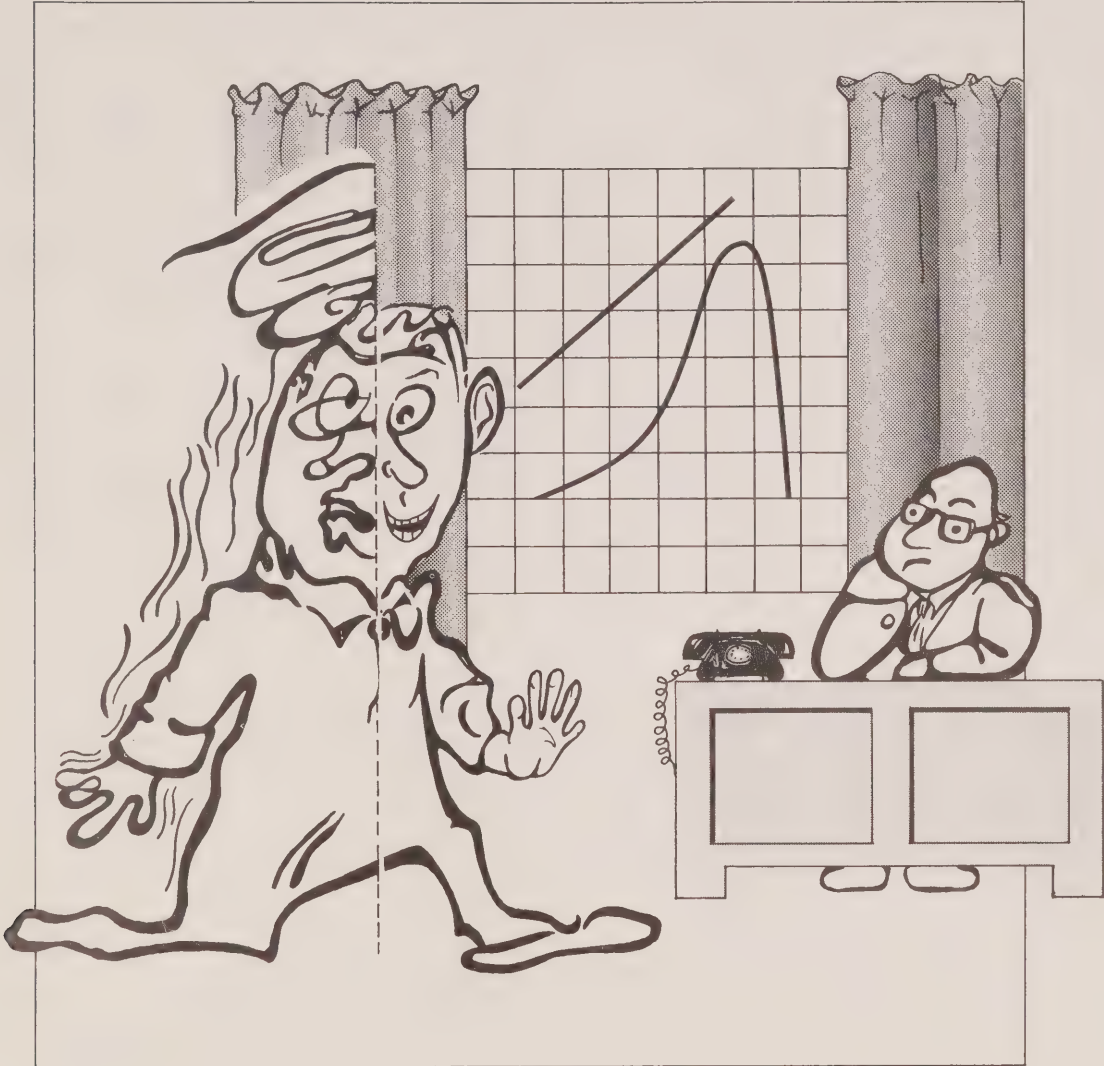
IDENTIFY: High risk dose levels
LIST: Categories of "gross risk indicators"

Module 3: RISK INDICATORS

OVERVIEW OF MODULE 3: RISK INDICATORS

Time required	60 minutes
Format	Large group – lecturette – discussion
Supportive materials	– Flipchart/blackboard – Risk-o-graph (APPENDIX D, p. II-51) – felt pens/chalk
Learning objectives	Ensure that participants can: 1. List and discuss six categories of gross risk indicators (physical, drug dose, marital/family, employment/financial; legal, leisure): 2. Use the Risk-o-graph in simulated cases.
Trainer qualifications	Clinical pharmacologist, clinical pharmacist, and/or physician with experience in the management of drug dependence.

ACTIVITY A

RISK ESTIMATES AND CATEGORIES

Time required	30 minutes
Format	Large group lecturettes and discussion
Supportive materials	– Flipchart/blackboard – chalk/felt pens
Learning objective	To enable participants to list objective and describe the six categories of gross risk indicators

Instructions For Training Activity A

Present a lecture covering the following key points briefly and allowing some time for discussion. The purpose of this lecture is to preview the key categories of assessment information used for treatment planning, which are covered in The Initial Interview (Unit III of this training package).

The trainer may begin by pointing out that:

– Calculation of reliable risk estimates is complex because of interaction of factors.

– Risk estimates for alcohol use patterns/levels can be more precise than for other drugs. Therefore, a comprehensive description of symptoms is important.

– Risk indicator areas for a comprehensive picture are described in the following sections.

Key Points

IN A DIAGNOSIS OF ALCOHOLISM, ALL AREAS OF SYMPTOMATOLOGY ARE EQUALLY IMPORTANT.

ASSESSMENT

In order that diagnosis may be made at the earliest possible stage, and appropriate and effective therapeutic intervention begun, it is essential to assess carefully the patient's physical, psychological, and social states.

PHYSICAL STATE

Generalities

– Evidence of loss of control of alcohol intake or change in tolerance to alcohol (increased tolerance in early stage, decreased tolerance in very advanced stage) are signs of alcoholism.

– Development of withdrawal symptoms which stop with further alcohol intake is a sign of alcoholism.

– Greatly increased incidence of trauma may be exhibited by those with alcoholic related diseases.

– Malnutrition is a major contributing factor, or plays a role in many medical complications of alcoholism.

– All body systems may be diseased directly or indirectly by alcohol abuse.

Physical Problems

– Respiratory

– Gastro-intestinal (Chronic gastritis, liver disease, etc.)

– Cardiovascular

– Neurological (Peripheral and CNS)

– Increased number of infections.

- Odour of alcohol on breath at examination/ interview

- Evidence of tolerance development (little or no effect at blood levels in excess of 150 mg)

- Flushed face or engorged blood vessels on face

- Abnormal liver function or obvious liver disease

- Sleep disturbances, nocturnal sweating

- G.I. disturbances (nausea, vomiting, diarrhoea, vague abdominal complaints)

- Irregularities in heart beat

- Evidence of behavioural impairment and resulting physical trauma (bruises on body and limbs, cigarette burns, frequent car accidents, etc.)

- Headaches

- Withdrawal symptoms

COMMON PSYCHOLOGICAL PROBLEMS[18] (GLOBAL INDICATORS)

Things to Know

- Alcoholics may manifest any psychological disorder existent in the general population. Such disorder may have been present before, or occur after the onset of alcoholism

- The "dependent personality" which characterizes many alcoholics may not be present in all; conversely, a person may exhibit that personality pattern without ever becoming an alcoholic

- Alcohol may be used to suppress uncomfortable feelings caused by psychosis

Things to Look For

- an underlying personality disorder with sociopathic behaviour

- anxiety and depression which are reactive in nature

- severe depression, and suicidal thoughts and attempts

- thoughts of low self-esteem and worthlessness easily elicited

- inability to identify and verbalize feelings

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[18] This outline focuses on problems associated with alcohol use. However, it applies well to other drug risks and problems.

    –   outburst of rage

    –   signs of uncontrolled alcohol consumption (heavy use, gulping drinks, surreptitious drinking, morning drinking, unsuccessful attempts to abstain, drinking despite strong contraindications, etc.)

Source: Addiction Research Foundation and Ontario Medical Association, *Diagnosis and Treatment of Alcoholism for Primary Care Physicians*, (Toronto: Addiction Research Foundation, 1978) pp. 14-16.

COMMON SOCIAL PROBLEMS (GLOBAL INDICATORS)

Marital and family

–   increased difficulty relating to spouse, characterized either by withdrawal or conflict, often with threats of separation or divorce

–   sexual difficulties

–   denial of alcohol-related family problems by patient

–   family indicates alcohol-related problems, even if denied by patient

–   family denies alcohol-related problems

–   increased minor medical and psychiatric problems in spouse

–   increased minor medical and psychiatric problems in children

–   increased incidence of alcoholism in other family members

–   frequent changes in residence

Employment and occupational symptoms

–   frequent and varied medical excuses for absence from work, especially Monday, Friday and immediately after payday

–   no advancement where expected

–   threat of job loss due to poor performance related to alcohol

–   history of frequent job changes, especially to employment which offers facilities for drinking

–   unexplained or poorly explained gaps in job history

–   difficulty in maintaining various aspects of home care

-   loss of friends
-   change in friends to include drinking buddies only
-   inability to have close, meaningful relationships
-   fear of close, meaningful relationships
-   social life revolves around drinking activities
-   less or no involvement in recreational activities

ACTIVITY B

RISK-O-GRAPH

Time required	30 minutes
Format	Large group exercises
Supportive materials	Risk-o-graph (in numbers sufficient for one for each participant) (APPENDIX D, page II-51)
Learning objective	To enable participants to practise objective using the Risk-o-graph.

Instructions For Training Activity B

1. Explain factors affecting risk, which limit the accuracy of the Risk-o-graph:

    Standard drink concept;
    dose (amount consumed in one drink);
    body weight and size;
    age;
    sex;
    nutritional state;
    general state of health;
    psychological factors;
    tolerance;
    situational factors;

2. Distribute one copy of the Risk-o-graph to each participant.

3. Describe the following case (or cases described by participants)

    A 250-pound man who averages 5 standard drinks per day;
    a 100-pound woman who averages 3 standard drinks per day;

a 130-pound man who averages 6 standard drinks per day;

4. Discuss the level of risk associated with each case.

5. Stress the importance of this kind of information in negotiating treatment planning with clients.

6. Refer to the training material covered in The Initial Interview (Unit III of this package) regarding levels of assessment of alcohol-related problems.

Module 4: CASE APPLICATIONS
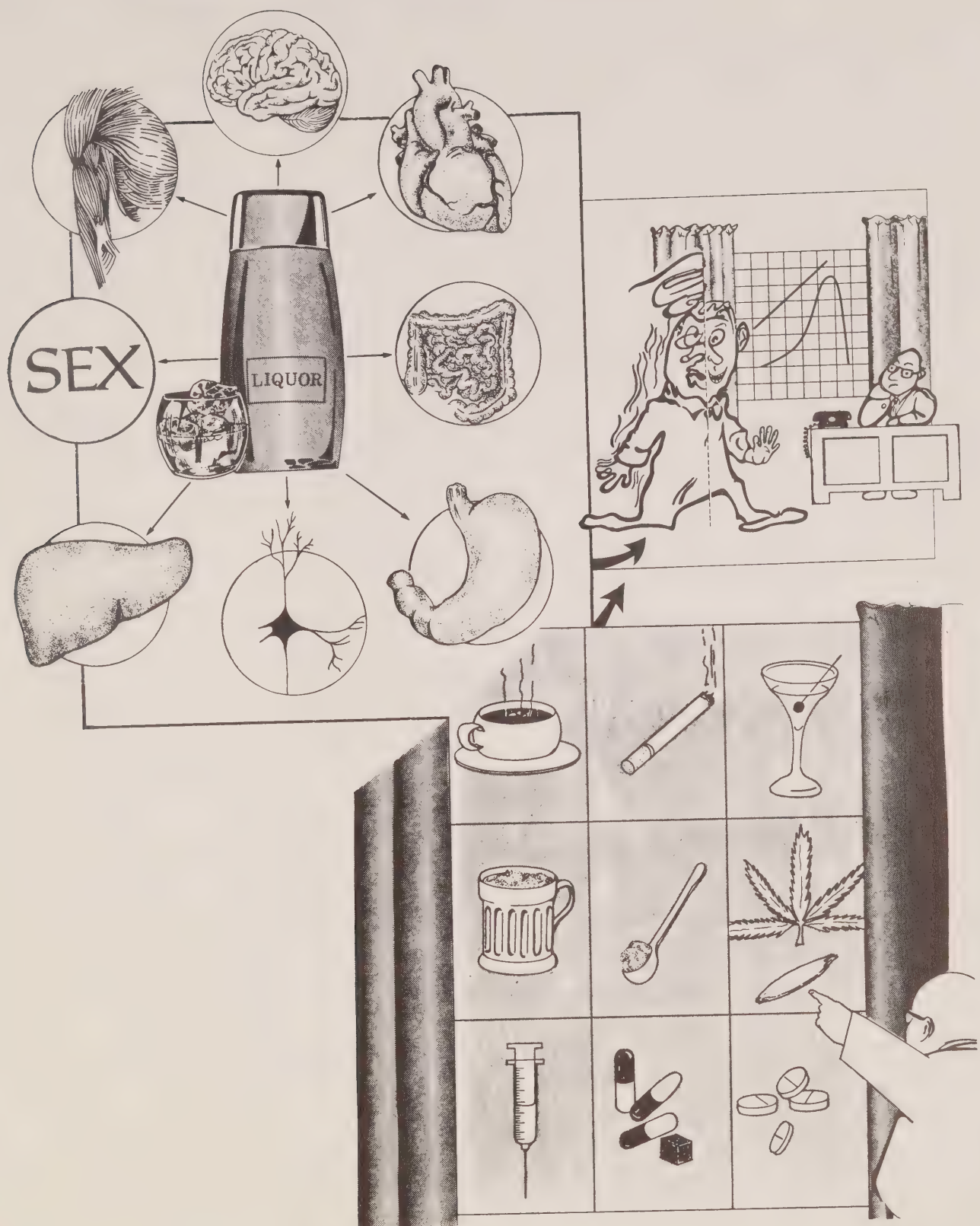
Module 4: CASE APPLICATIONS

OVERVIEW OF MODULE 4: CASE APPLICATIONS

TRAINER'S NOTES

Time required	105 minutes
Format	Large group
Supportive materials	– Flipchart/blackboard – felt pens/chalk
Learning objective	Ensure that participants can: 1) discuss how the special hazards and risks associated with drug use relate to the counselling interview process in terms of acute and chronic effect.
Trainer qualifications	Clinical pharmacologist, clinical pharmacist, and/or physician with experience in the management of drug dependence.

ACTIVITY A

DRUG INTERACTION EFFECTS

Time required	60 minutes
Format	Large group lecturette
Supportive materials	– Flipchart/blackboard – chalk/felt pens – DRUG RISK CHECKLIST
Learning objectives	Participants will be able to: 1. differentiate three categories of drug interaction effects 2. describe and discuss toxic drug effects of mixing alcohol with seven commonly used drugs.

Instructions For Training Activity A

Introduction (First 15 minutes)

Begin by noting that a drug interaction is something that occurs when one or more drugs present in the body alter the action or effects of another drug present in the body at the same time.

Stress that, although this may seem obvious, or has previously been discussed, it is of considerable importance (on its own) because of the growing incidence of poly drug use. This is especially true with the many new drugs appearing on the various markets.

If individual drug effects are difficult to predict, drug interactions are even more so, in some instances. However, some drug interactions are predictably lethal.

Key Points

Elaborate briefly on the following, giving examples:

1) Drugs taken together may act independently of each other

2) Drugs taken together may enhance each others' effects

3) Drugs taken together may have an antagonistic effect

Note that the above are influenced by variations in:

1) dose – time response factors;

2) Other factors such as size, sex, nutrition, health, psychological factors and tolerance.

Point out that some very commonly encountered drug interactions involve combining alcohol use with prescription or across-the-counter drugs. Comment briefly on the likely effects of the following combinations of alcohol with other drugs:

1) alcohol and barbiturates

2) alcohol and tranquillizers;

3) alcohol and antihistamines;

4) alcohol and ASA;

5) alcohol and insulin;

6) alcohol and stimulants;

7) alcohol and disulfiram.

Indicate that, for the remaining 45 minutes or so, participants would apply this information to a case situation.

Case Example Exercise (45 minutes)

The trainer begins by describing him/herself as a client with the following characteristics: (Although an example is given below, it is preferable for the trainers to make up their own example(s) based on their own, or local case circumstances.)

- — Female
- — Age 23
- — Height 5′2″ (157 cm.)
- — Weight 102 pounds (46 kg.)
- — Marital status: single but engaged
- — Main concern: "blackouts"/insomnia following heavy drinking
- — Appearance: tired/face flushed
- — Speech: somewhat slurred
- — Employment: taxi driver
- — Previous treatment history: medical emergency detoxication

The context is an assessment/information and referral centre, at which the client has just now arrived.

The task of the group is to ask the client (the trainer) some preliminary questions designed to assess the degree of immediate risk. That is, "does this client require an immediate medical referral?"

Participants should be directed to the DRUG RISK CHECK-LIST in their manual for reference in formulating questions. (pages II-53 to II-54 in Participant's Manual)

After the participants have asked as many questions as they feel are necessary, the trainer should give feedback on which questions were most relevant and which (if any) questions were not asked, but should have been.

In this particular case the possible risks which are most apparent involve determining possible alcohol – barbiturate use, possible pregnancy – drug risk, and possible impaired driving risk.

However other cases might be used to focus on issues more relevant to the participants in the training group.

Finally, after answering any final questions, point out that materials in Unit III of this package (The Initial Interview) are designed to help organize various levels of assessment.

ACTIVITY B

CONCLUSION

TRAINER'S NOTES

Time required	45 minutes
Format	Large group discussion
Supportive materials	– Flipchart/blackboard – felt pens/chalk
Learning objective	To enable participants to recognize common high risk drug use situations and feel more confident in seeking specialized consultation.

Instructions For Training Activity B

Begin by referring back to the Risk-O-Graph as an example of how chronic effects of alcohol use can present serious health risks after protracted periods of time. Also remind the group of the numerous short-term (acute) effects. Ask the question: "Why do counsellors need to know something about drugs and misuse effects when counselling clients with drug-related problems?"

Write down the response on the blackboard or flipchart, while encouraging alternative views from other participants and clarifying the points made. This should take approximately 30 minutes, including the trainer's suggested additions to the list.

In a summary lecturette (referring to the points listed by the participants) it should be pointed out that, although it might seem very obvious, counsellors can easily overlook the opportunities provided by practical drug knowledge including:

1) help in motivating clients to consider change;

2) detection of high risk situations involving:

- overdose;

- lethal drug interactions;

- acute withdrawal;

- impaired judgment;

3) prevention of secondary risks, such as foetal alcohol syndrome;

4) a means of increasing their credibility as a counsellor;

5) the development of more objective attitudes toward drug-use behaviour;

6) improved ability to interpret clients behaviour and appearance;

7) increased feeling of confidence in seeking specialized consultation;

8) increased ability to provide feedback and constructive confrontation more precisely regarding client behaviour;

9) improved ability to ask more relevant probing questions;

10) other advantages, as described by participants.

The trainer may close the session by suggesting the reading and/or review of the Participant's Manual section on Practical Drug Concepts, and point out that Unit III (Initial Interview Methods) will further integrate this material on drug concepts with the previous Unit concerning counselling communications.

APPENDIX A

DRUG CLASSIFICATION EXERCISE

TRAINER'S NOTES

Time required	45 minutes
Format	Small groups Large group discussion
Supportive materials	– Handouts a) "How Do We Classify Drugs?" (page II-42) b) "Drug Classification Table" (page II-44)
Learning objectives	1) To have participants recognize certain drugs representative of the major classes of psychoactive drugs; 2) To ensure that participants can list some generic names of medicinal agents; 3) To have participants describe one scheme for classification of psychoactive drugs and to explain the limitations of this method.

Instructions For Drug Classification Exercise *

Discussion:

Prior to the exercise, reduce the participants' anxiety by explaining the purpose of the task. Tell them that it is not intended to be a test of their knowledge, and that they can omit or ask their neighbours about any unfamiliar substances on the list.

After the exercise, go quickly through the list of drugs, making sure that the participants know what each agent is and which pharmacological class it is an example of (e.g., diazepam (Valium ®) is an antianxiety agent).

Poll the group quickly to ascertain into which column the majority would place each substance and whether there are any divergent opinions. It is likely that there will be considerable disagreement. Explain that the reasons for this will soon be clear.

With each category of drugs, explain which groups of agents are included and what pharmacological characteristics they have in common. The points to cover are summarized below and drugs listed in the exercise are included in parentheses.

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*If it is not possible to distribute this exercise prior to the course, it may be used at the beginning of the program.

Depressants

- drugs which generally suppress CNS activity. However, there may be an initial period of "disinhibition" during which the drug may appear to be acting as a stimulant.

- groups of drugs include:

  - sedative/hypnotics

    - barbiturates (secobarbital)

    - non-barbiturates sedative/hypnotics (methaqualone)

  - alcohol (whiskey)

  - antianxiety agents (diazepam)

  - general anaesthetics (ether) and inhalants (toluene)

  - some antihistamines (chlorpheniramine)

  - opioids (heroin) are sometimes placed in a category of their analgesic properties, but can also be included with the depressants because of their sedative effects

  - a legitimate argument for placing cannabis (marijuana) and PCP (phencyclidine) into this category (in addition to under hallucinogens) can be made.

Stimulants

- drugs which increase CNS activity

- groups of drugs include:

  - amphetamines (dextroamphetamine)

  - (cocaine)

  - at high doses this drug also has depressant effects (i.e., respiratory depression)

  - nicotine (tobacco) – primarily a stimulant, but may also have some depressant effects

  - (caffeine)

  - decongestants (phenylpropanolamine or PPA) – found in OTC nasal decongestants, some diet pills imported from the U.S., and "look-alike" stimulants.

Hallucinogens:

- alter perception, mood, cognition , etc.

- groups of drugs include:

  - LSD-like (lysergic acid diethylamide)

- mescaline-like (methylenedioxyamphetamine or MDA) – also have stimulant effects

- PCP (phencyclidine) – also has depressant effects

- cannabis (marijuana) – also has depressant effects

Hallucinations are also sometimes reported during periods of acute intoxication with a variety of depressants (e.g., inhalants), during stimulant-induced psychotic episodes, or during withdrawal from depressants (e.g., alcohol).

Psychotherapeutic Agents:

- drugs used in therapy of specific psychiatric disorders

- produce effects usually perceived as unpleasant in normal individuals and therefore not subject to non-medical use

- groups of drugs include:

  - antipsychotic agents (chlorpromazine)

  - antidepressants (imipramine)

  - (lithium) – used to treat bipolar disorders

Conclusion:

This scheme is not universally helpful since so many drugs have mixed effects. In fact, schemes of this type are now being abandoned by some pharmacologists. However, in the absence of anything better, the scheme has been retained here, since it does provide for the non-pharmacologist a framework for understanding at least the primary actions of the major groups of psychoactive drugs.

(Refer to pages II-14 to II-37 in Participant's Manual, to review "Drug Classifications")

HANDOUT: HOW DO WE CLASSIFY DRUGS?

Keeping in mind the definitions below, place the following drugs into the appropriate column of the drug classification table.

Depressant:

A substance that depresses ("slows down") the communication of cells in the central nervous system (CNS). Note the distinction between CNS depression and mood depression. CNS depressants do not necessarily depress mood.

Stimulant:

A substance that stimulates ("speeds up") the communication between cells in the CNS.

Hallucinogen:

A substance that does not necessarily depress or stimulate CNS function, but changes it in such a way that the processes of perception, cognition, memory and emotion are altered.

Psychotherapeutic Agent:

A substance that is administered therapeutically in the treatment of specific types of psychopathology. Most produce unpleasant side-effects and little if any euphoria. Therefore they are seldom used for non-medical reasons.

Drugs To Be Classified:

1. whiskey
2. marijuana
3. chlorpheniramine
4. cocaine
5. ether
6. caffeine
7. secobarbital
8. toluene
9. acetylsalicylic acid
10. heroin
11. lithium
12. dextroamphetamine
13. diazepam
14. chlorpromazine
15. methaqualone
16. phenylpropanolamine
17. imipramine
18. lysergic acid diethylamide
19. phencyclidine
20. methylenedioxyamphetamine

DRUG CLASSIFICATION TABLE

Depressants	Stimulants	Hallucinogens	Psychotherapeutic Agents

SHOPPING LIST EXERCISE

Supportive   – Handouts
materials   – a) "Shopping List for a Trip to China" (page II-49)

Learning   1) To encourage the participants to develop their
objectives   own definition of the term "drug" by choosing
                   what they consider to be drugs from a list of
                   popular preparations.

                2) To familiarize the participants with the concept of
                   "active ingredients" and the distinction between
                   proprietary (trade or brand) names and generic
                   names of products.

                3) To reinforce the distinction between over-the-
                   counter drugs and prescription medication.

                4) To introduce the term, "psychoactive drug" as a
                   substance affecting perception, mood, cognition,
                   psychomotor function, etc.

PRE-COURSE ASSIGNMENT
(To be distributed prior to the course)

Exercise: Shopping List for a trip to China

You are a healthy individual going for a four-week trip to China.
You have been told by your travel agent that the availability of
Western style cosmetics and medications will be limited and that
you should bring any necessary products with you. Wanting to be
ready for all eventualities, you prepare the following shopping list:

- a sunscreen lotion
- a sunburn lotion containing a local anaesthetic
- an insect repellant
- an antacid
- a laxative
- a diarrhoea suppressant
- an analgesic containing codeine
- an antianxiety agent
- a sleeping pill preparation
- a cough suppressant
- an allergy medication
- dandruff shampoo
- toothpaste with fluoride
- athletes' foot powder or cream

- — a vitamin supplement

- — an antibiotic

- — an antiperspirant

- — add anything else you think you might need to the list.

Together with your physician and your pharmacist, you choose and purchase products belonging to each category on your list. As you pack your suitcase, you become curious about some of the ingredients and their effects, and you decide to find out more about them. On the table provided (page II-49) list the following information for each product:

1. The brand or proprietary name of the chosen product.

2. Active ingredients (which, for the most part, can be found on the package of over-the-counter medications and cosmetics). If the item is a prescription drug, list the generic name (e.g., diazepam is the generic name of the antianxiety agent, Valium®).

3. Is a prescription necessary to buy the chosen brand? Enter yes/no in the table.

4. Do you think that the preparation should be considered a drug? Enter yes/no in the table.

Information can be obtained by looking in your own medicine cabinet, browsing through your pharmacy, speaking to your pharmacist, or looking at books such as the *Compendium of Pharmaceuticals and Specialties*, published yearly by the Canadian Pharmaceutical Association.

DRUG CLASSIFICATION EXERCISE

Exercise Instruction

The exercise is intended to be distributed to the students in advance of the course, so that it can be discussed as part of the introductory material. All of the questions can be raised prior to the start of module 1 as a means of orienting the participant to the course. Alternately, different sections of the exercise can be addressed as the course progresses.

Definition of the Term "Drug"

The students will probably disagree about which substances on their lists should be classified as drugs. They should be assured that the line of division between drugs and non-drugs is not sharp, and that similar disagreements would probably exist among any group of pharmacists or pharmacologists. The concept of intention is important. For example, vitamins, when administered therapeutically, would be considered drugs. When taken as part of a normal diet, they would not be thought of as drugs.

In general, cosmetics, sunscreens, and insect repellants would not be considered drugs. The classification of antiperspirants, medicated shampoos and fluoridated toothpaste is difficult, and opinions may be divided. Ingredients in these preparations are intended to alter normal body function in a particular way, and could be thought of as drugs. The other products are clearly intended to produce therapeutic or behavioural effects, and hence would be considered drugs.

Active Ingredients and Generic Names

The active ingredients in over-the-counter (OTC) medications are generally listed on the package. This is not true for cosmetics. Non-prescription products sometimes contain small amounts of other active substances that are not listed on the label. (For example, Benylin cough syrup contains 5% alcohol.) Some of these hidden ingredients may cause adverse effect in persons with unusually high sensitivity to them (i.e., those with allergies or taking certain medications).

The difference between proprietary names (e.g., diazepam) should be stressed, since this distinction is often an area of confusion.

Requirements for Prescription

Prescriptions are required for antianxiety agents; antibiotics; sleeping pills except for those containing antihistamines; and some analgesics, cough syrups and antidiarrhoeals containing opiates depending on the amount per unit dose, and the presence of other ingredients in the preparation.

Psychoactive Drugs

Preparations on the list that would be considered potentially psychoactive include those containing opioid analgesics (e.g., codeine), caffeine, antihistamines, alcohol, antianxiety agents and barbiturates. Decongestants and local anaesthetics can also produce pyschoactive effects when taken systemically at high doses. Many OTC compounds containing small amounts of psychoactive substances produce minimal effects on behaviour when taken as directed.

CNS depressants on the list include codeine, antianxiety agents, sedative/hypnotics, antihistamines and possibly alcohol (if present in any mixtures as a solvent); CNS stimulants include caffeine (in the analgesic) and decongestants. Some drugs such as local anaesthetics produce mixed effects and are difficult to classify.

HANDOUT: SHOPPING LIST FOR A TRIP TO CHINA

Preparation	Brand Chosen	Active Ingredients/ Generic Name	Is it a Drug? yes/no	Prescription Needed? yes/no	Psychoactive Effects yes/no
1. sunscreen					
2. sunburn lotion and local anaesthetic					
3. insect repellant					
4. antacid					
5. laxative					
6. antidiarrheal					
7. analgesic & codeine					
8. antianxiety agent					
9. sleeping pill					
10. cough suppressant					
11. allergy medication					
12. dandruff shampoo					
13. toothpaste and fluoride					
14. athletes' foot medication					
15. vitamin supplement					
16. antibiotic					
17. antiperspirant					
18.					
19.					
20.					

APPENDIX D

ALCOHOL EQUIVALENTS (STANDARD DRINKS)

BEVERAGE	USUAL SERVING	STANDARD DRINKS PER SERVING	USUAL SIZE BOTTLE	STANDARD DRINKS PER BOTTLE
Beer (5%)	340 mL (12 oz)	1.0	340 mL (12 oz)	1.0
Table wine	140 mL (5 oz)	1.0	750 mL (26.4 oz) 1000 mL (35.2 oz) 1500 mL (52.8 oz)	5.3 7.0 10.6
Fortified wine	99 mL (3.5 oz)	1.0	750 mL (26.4 oz)	7.5
Spirits	43 mL (1.5 oz)	1.0	340 mL (12 oz) 710 mL (25 oz) 1135 mL (40 oz)	8.0 16.6 26.6

CONVERSION FACTOR: 1 IMPERIAL OUNCE = 28.4 mL

1 STANDARD   340 mL (12 oz)   Beer
   DRINK   =   140 mL (5 oz)   Table wine
                99 mL (3.5 oz)   Fortified wine
                43 mL (1.5 oz)   Spirits

Weight

lbs.	kg.

Minimal
Risk

Increased
Risk

Definite Damage

A graphic representation of the
Risk of Physical Damage from
alcohol consumption as a
function of average daily
alcohol intake and body weight
for a person of medium fat
content. For fatter persons (less
body water by proportion) the
risk is greater. For leaner
individuals the risk is a bit less.

Mean number of standard drinks per day

RISK-O-GRAPH

For healthy people the best evidence indicates that consumption of more than 3 or 4 standard drinks daily by an individual of 70 kg. (155 lbs.) carries an increasing risk to health. Consumption of 6 or more "standard drinks" daily by the same individual is generally accepted as the level at which definite physical damage begins to accrue. This graph assumes a steady rate of daily ingestion; however, one may have a low average daily intake yet still drink hazardously on sporadic occasions. This carries great risk of acute physical damage, accidents and death even though average daily consumption is in the minimal risk range.

The effects of alcohol depend on the amount taken (dose); the frequency of consumption; the rate of absorption; the metabolic rate; the body weight; the proportion of body water and the general state of health of the consumer. These factors all vary somewhat not only **between** individuals but **within** a given individual at different times. However, with few exceptions body weight and dose × frequency are the major relevant variables which predict the risk of damage from drinking in healthy individuals. The longer a given level of drinking is maintained (weeks, months, years) the greater the probability of permanent damage.

The figure provides a graphic representation of the risks of **physical** damage associated with various levels of alcohol consumption for individuals of various weight. However it must be recognized that with certain types of diseases the risk increases **faster** than the graph indicates. It should be emphasized that the boundaries between risk levels are arbitrary and the increasing risk is part of a continuum. When in doubt one should err on the side of caution in assessing the hazard of physical damage.

APPENDIX E

WHAT IS A DRUG?

CLASSIFICATION SHEET EXERCISE

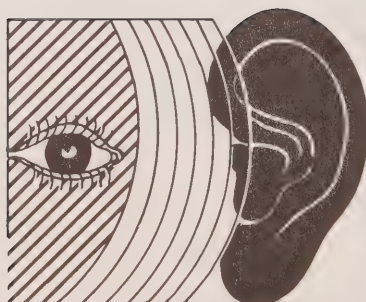**Instructions:**

Classify these substances as drugs or no-drugs in the following table: salt, tetracycline, DDT, coffee, vitamin C, Paraquat, sugar.

Drug   *Non-Drug*

Question: What makes a substance a drug?

III

INITIAL
INTERVIEW METHODS

UNIT III
INITIAL INTERVIEW METHODS – TRAINER'S MANUAL

TABLE OF CONTENTS

INTRODUCTORY PERSPECTIVE

This Unit is intended to train addiction counsellors to more fully understand the value and relevance of assessment interviewing, to increase participant knowledge and skills in the conduct of an initial interview and to provide a framework for the organization and recording of information collected in the assessment process.

This Unit builds on the combination of counselling communication skills and practical drug concepts to describe and practise methods of conducting initial interview. The focus is on: how to get started; how to explain and how to conduct structured and other forms of assessment interviews.

Effective interviewing for assessment, for referral and/or for treatment planning requires more than interpersonal skills and specialized knowledge. The counsellor also needs to understand and practise effective interview methods. Forms for gathering and organizing a wide variety of client information are often required administratively, and counsellors often find these to be difficult to integrate into interviews. Although particular instruments, policies, and procedures employed should be consistent with the trainees' work settings, some examples are provided. As well, a videotape is available for demonstration purposes through the Addiction Research Foundation's School For Addiction Studies and Education Resources Division.

In closing, it should be noted that the trainer for this Unit would ideally be an experienced clinician with practised training experience. As well, participants should be encouraged to arrange for supervised practice of initial interviewing skills until they have mastered them sufficiently. Users of this module, as with others in this package, should assume that MUCH MORE TIME and PRACTICE are needed to adequately learn the concepts and skills presented. Thus, the need for CONTINUED TRAINING as discussed in the Introduction Unit.

Before beginning this Unit, trainers must ensure that they have completed the following three preparatory steps:

1) The trainer should have read the training manual and accompanying appendices thoroughly to ensure a sound understanding of content.

2) The trainer should have a "dry run" with all materials (e.g., videotape), instructions, and exercises that they are not absolutely familiar with. This will ensure that trainers fully understand the training methodology.

3) The trainer should gather all materials and equipment beforehand and test them to ensure a smooth flowing training session. This is particularly critical with regard to audiovisual equipment to ensure knowledge of operation and compatibility of videotapes with playback units.

A sample schedule for this Unit, has been included on pages III-7 and III-8. If trainers choose to use this schedule, they must send out Participant's Manuals well ahead of the training event. (It may be advisable to telephone each participant about one week prior to the event to ensure that they have received the material and to explain again to them how important it is to read it.)

If the trainer wishes to expand the time-frame for this Unit, time could be allowed for segments of the manual to be handed out and read during the session time.

A final comment relates to the structure of the Unit. It has been constructed so that it may be used as a whole, or modules may be independently selected for use on their own.

OBJECTIVES

INITIAL INTERVIEW METHODS
MODULE 1: ASSESSMENT

Goals/Objectives

The goal of this module is to make the participants aware of the importance and function of assessment in relation to treatment.

At the conclusion of this module, participants should be able to explain the relevance of assessment to the counselling process and distinguish between three levels of assessment (brief screening, basic comprehensive, and specialized).

MODULE 2: THE INTERVIEW

Goals/Objectives

The goal of this module is to present a framework for structuring an initial interview and to examine some practical issues related to beginning the process of assessment.

At the conclusion of this module, participants should be able to describe and demonstrate how to begin an initial interview, identify 10 major content areas of a thorough client assessment, and describe four major principles of assessment.

MODULE 3: SIMULATION

Goals/Objectives

The goal of this module is to present and analyze a sample initial assessment interview, then allow participants to model assessment skills in a role play situation.

At the conclusion of this module, participants should be able to integrate the material of the Practical Drug Concepts Unit with Basic Communication Skills, and demonstrate these in a simulated initial interview situation.

MODULE 4: ASSESSMENT DOCUMENTATION

Goals/Objectives

The goal of this module is to review the major elements of this Unit and to integrate the concept of systematic record keeping.

At the conclusion of this module, participants should understand the relevance of assessment to the counselling process, be able to demonstrate how to conduct an initial interview, and be able to complete and maintain appropriate records related to assessment of clients.

SAMPLE SCHEDULE

UNIT III: INITIAL INTERVIEW METHODS

SAMPLE TIMES	TIME REQUIRED	TITLE	ACTIVITY/ FORMAT	MATERIALS	PAGE
9:00	20 min.	**Module 1** Assess-ment	Activity A – Orientation Lecturette – – large group lecturette	Flipchart/blackboard felt pens/chalk	III-11 to III-12
9:20	40 min.		Activity B – Card Game – large group exercise	– Cards (Appendix A)	III-13 to III-14
10:00	25 min.	**Module 2** The Interview	Activity A – Beginning the interview – large group exercise and discussion	Flipchart/blackboard felt pens/chalk	III-17 to III-20
10:25	15 min.	BREAK			
10:40	50 min.		Activity B – Case Study – large group discussion and small group exercise	Case study (Appendix C) Handout titled 'Life Areas' (p. XX) ASIST (Page XX Participant's Manual) Flipchart/ blackboard felt pens/ chalk	III-20 to III-23
11:30	45 min.	**Module 3** Simula-tion	Activity A – Videotape demonstration – large group	Videotape, playback unit and monitor	III-27 to III-28

SAMPLE SCHEDULE

UNIT III: INITIAL INTERVIEW METHODS

SAMPLE TIMES	TIME REQUIRED	TITLE	ACTIVITY/ FORMAT	MATERIALS	PAGE
12:15	60 min.	LUNCH			
1:15	60 min.	**Module 3** (Cont'd)	Activity B – Practice – small group	None	III-29
2:15	30 min.	**Module 4** Assessment Documentation	Activity A – Records – large group discussion	Overhead projector, transparencies, handouts pages flipchart/blackboard felt pens/chalk	III-33 to III-36
2:45	30 min.		Activity B – Conclusion – large group discussion	flipchart felt pens	III-36

Module 1: ASSESSMENT
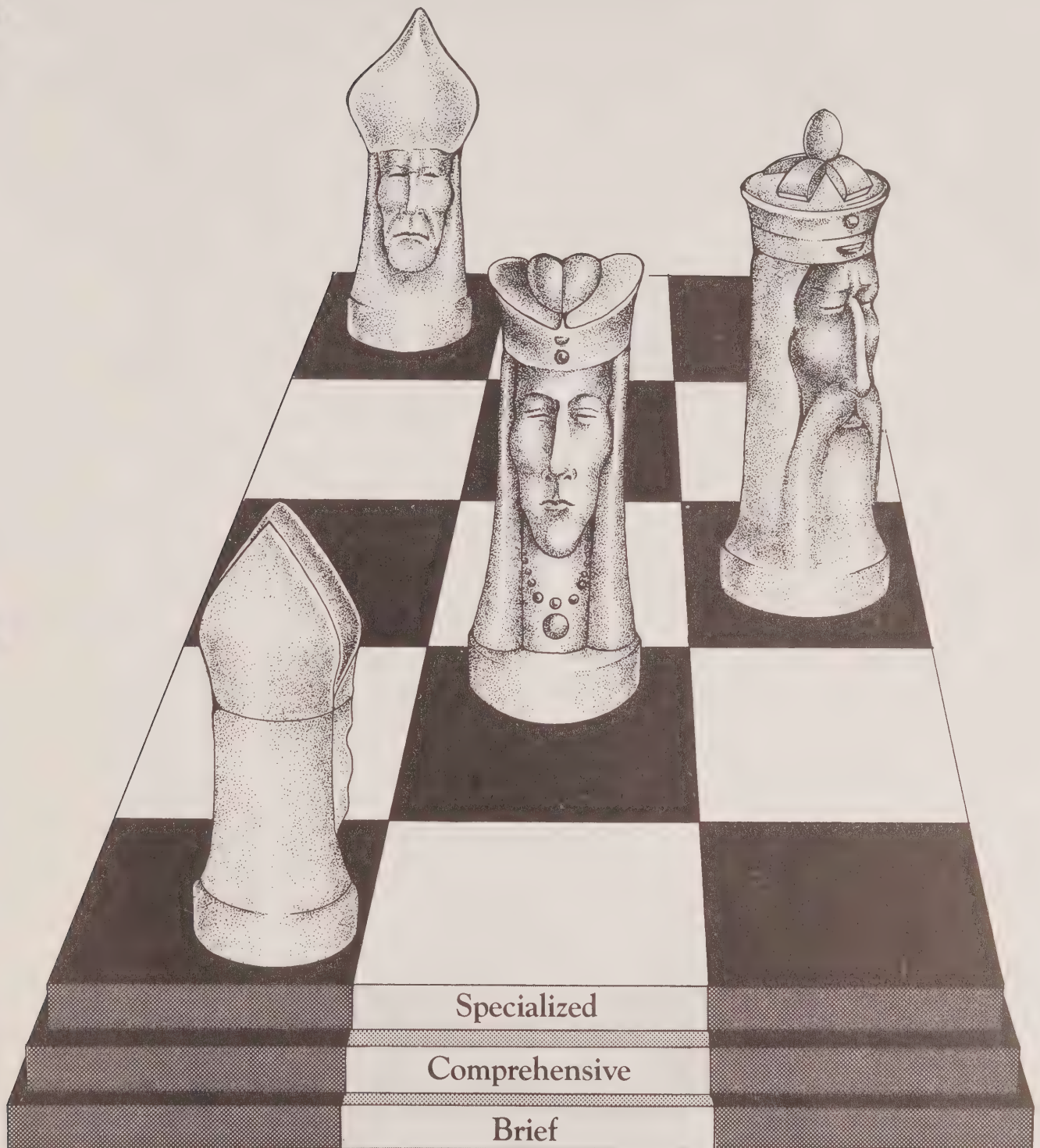
Specialized

Comprehensive

Brief

ASSESSMENT: Explain the relevance of assessment to the counselling process

DISTINGUISH: Level of assessment

Module 1: ASSESSMENT

OVERVIEW OF MODULE I: ASSESSMENT

TRAINER'S NOTES

Time required	Approximately 60 minutes
Format	Large group – lecturette, Large group exercise.
Supportive materials	– Flipchart/blackboard – card game – (Appendix A) – felt pens/chalk
Learning objective	At the conclusion of this module, participants should be able to explain the relevance of assessment to the counselling process and distinguish between 3 levels of assessment.

ACTIVITY A

ORIENTATION LECTURETTE

Time required	20 minutes
Format	Large group lecturette/discussion
Supportive materials	Flipchart/blackboard felt pens/chalk
Learning objectives	To have participants understand the relevance of assessment in the counselling process and to give them a basic understanding of three sequential levels of assessment.

Instructions For Training Activity A

The trainer should stress from the outset that assessment is to be considered in the total context of the counselling process and that the knowledge and skills of this Unit are most effective in the context of:

-   adequate specialized counselling skills/ knowledge;

-   acceptable ethical standards of confidentiality;

-   constructive attitudes towards helping clients, e.g., empathy, positive regard.

During this 20-minute orientation the trainer should review the material on page III-12 of the Trainer's Manual and on pages III-9 to III-10 of the Participant's Manual. Since this material is to have been read by participants prior to the time, a question and answer process is recommended as an alternative to a lecturette.

Trainers are encouraged to develop innovative approaches to the presentation of this material once they are experienced with it.

Key Points

1) Three sequential levels of assessment;

    (a) brief screening;

    (b) basic comprehensive;

    (c) specialized assessment.

2) Brief screening leads to either:

    (a) clean bill of health;

    (b) basic comprehensive assessment;

    (c) specialized assessment.

3) Basic comprehensive assessment leads to:

    (a) provision of treatment by assessor;

    (b) referral for treatment elsewhere;

    (c) referral for specialized assessment.

4) Types of assessment:

    (a) standardized interview;

    (b) psychosocial.

5) Focus of this Unit:

**BASIC COMPREHENSIVE
ALCOHOL ASSESSMENT**
(psychosocial format)

6) The more information you can get from as many sources as possible, the better treatment you can provide or by referral you can make:

    — the best MATCH;

    — the most accurate mutual problem definition.

ACTIVITY B

CARD GAME

Time required	Approximately 40 minutes
Format	Large group experience
Supportive materials	– Cards from Appendix A materials
Learning objectives	Participants should gain a personal objective understanding of the relevance of assessment to the helping process.

Instructions For Training Activity B

In preparation for this game, the trainer should have cards piled on tables around the perimeter of the room and have each pile clearly marked by resource category.

The trainer will begin by stating that this is an exercise in assessment and referral and that the group will have an opportunity to discuss the experience once we have finished it.

The timing for the exercise is flexible, but 20-25 minutes is the minimum suggested.

The objective of this game is to illustrate:

1) the many obstacles to making a successful referral;

2) the importance of assessment information being accurate, so that the confusion in the service network can be minimized.

This will be discussed at the conclusion of the exercise.

Directions For Game

1) Hand each of the participants a card from the *DRUNK* pile and ask them to follow the instructions on all cards. (Refer to Appendix A for the card game.)

   The identification card tells them what their problem is and where to start seeking help (DRUNK)

2) After a card in each resource category pile is read, it should be placed at the bottom of the pile.

TRAINER'S NOTES   The trainer should continue the game until participants have had the opportunity to go to several different piles. This game is very good for "getting things rolling" in the sense that it is both a good energizer and is focused. This game can also get very noisy (usually a good sign).

At the conclusion of the game, debrief by having a discussion beginning with how it felt to play the game. Ask participants what they felt the objectives of the game were. Conclude by introducing module 2.

Module 2: INTERVIEW
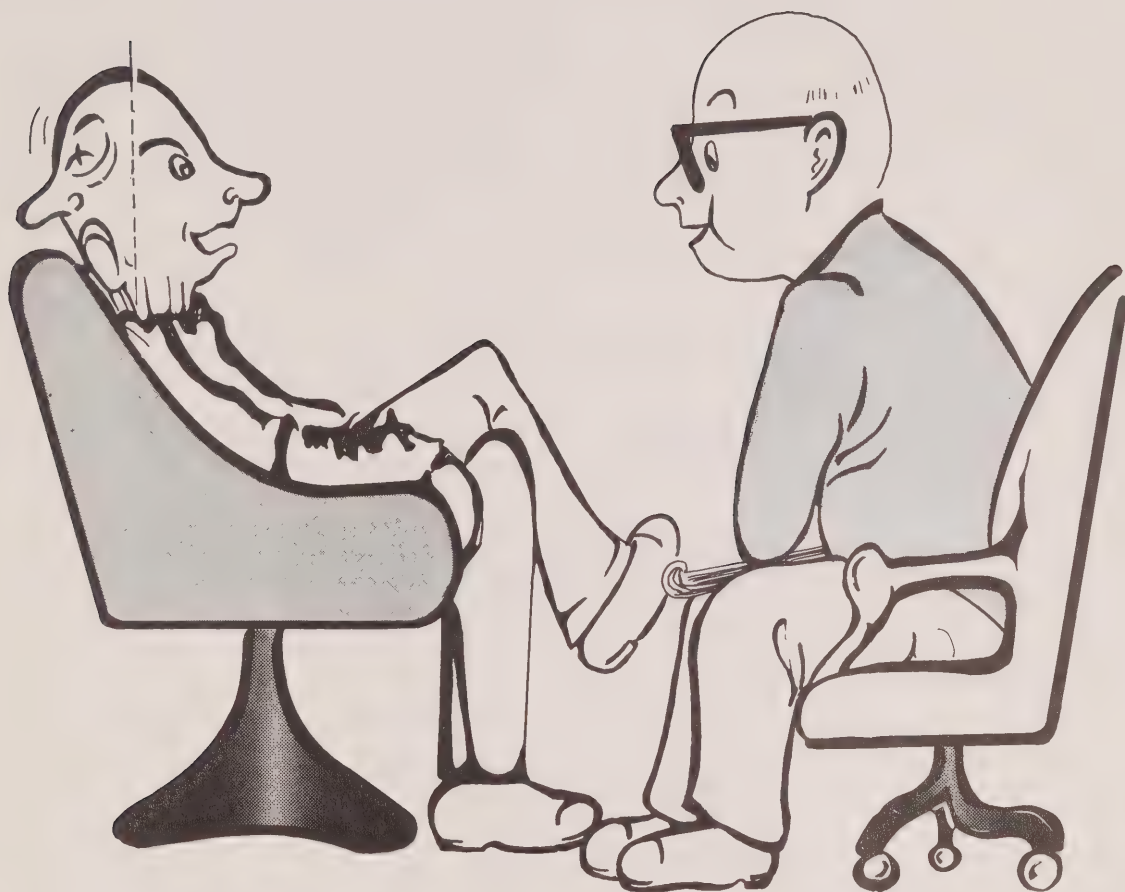
Module 2: INTERVIEW

OVERVIEW OF MODULE 2: THE INTERVIEW

Time required 1 hour, 15 minutes to complete Activities A and B

Format Large group discussion, lecturette and exercise as well as small group exercise.

Supportive materials
– Blackboard/flipchart,
– handout (Life Areas diagram, page III-23.)
– Case Study, Appendix C
– ASIST (page III-44 in Participant's Manual)
– Appendix B (page III-41): optional
– chalk/felt pens

Learning objectives At the conclusion of this module, participants should:

1) be able to describe and demonstrate how to begin an initial interview,

2) identify 10 major content areas of a thorough client assessment, and describe 4 principles of assessment;

3) be able to demonstrate how to manage one's negative attitudes, by checking out assumptions generated in the interview.

ACTIVITY A

THE INTERVIEW

Time required 25 minutes

Format Large group – discussion and exercise

Supportive maerials
– Blackboard/flipchart
– Appendix B (page III-41) optional
– chalk/felt pens

Learning objectives At the conclusion of this module, participants should be able to:

1) describe how to begin an assessment interview through the use of appropriate opening statements, a clear explanation of the role of the interviewer and an unambiguous description of the assessment proess;

2) identify their own attitudes and demonstrate how to manage them therapeutically.

Instructions For Training Activity A

Warm-up

Begin by telling participants that you would like to have them consider the following case situation and then break into dyads or triads to role play their response.

1) Mr. S. is an outpatient who is coming to you for the first time, having been referred from an inpatient medical ward. He has had a medical assessment and has been placed on Antabuse to help in abstaining from alcohol during the rest of his assessment because he has had frequent relapses before in similar situations.

2) He arrives for his first appointment with you on a Monday morning, 15 minutes late. When the receptionist notifies you of his arrival, she indicates that "he doesn't look good, if you know what I mean".

3) When Mr. S. enters your office you note that his face is very flushed, he is looking at the floor (avoiding eye contact), and he looks very tired.

4) With one person role playing the counsellor and one person role playing Mr. S., begin the interview, taking into account what you know already, and what you have seen so far.

5) Change roles after about two minutes, so that each person plays both roles. (The trainer should keep time and notify participants when they should change).

Discussion

After the role playing ask participants what they experienced in both roles, and write these points down on the board/flipchart.

Lecturette: Attitude and Assumptions

Point out that the discomfort felt during the role play was mostly due to the natural assumption that Mr. S. has been drinking and not knowing how to talk about it. Point out further that this did not have to be the case. That is, he may have been walking in a cold wind, had cough medicine (which he did not realize had alcohol in it) for a cold, had car trouble, or some combination of these.

Refer back to the Counselling Communications Skills material on "feedback and assumptions".

Attitudes can be analyzed as being made up of:

– *Beliefs* (information/theories);

– *Values* (views based on morals and experiences);

– *Intentions* (anticipated actions).

Attitudes can be negative (unhelpful) if they contain false beliefs and/or values incompatible with those of the client, and/or intentions incongruent with client personal needs and wishes.

Negative (unhelpful) attitudes can often be expressed destructively through incorrect assumptions. For example: Mr. S. is late, his face is flushed, he looks nervous, he is on antabuse. *Therefore*, he must have been drinking. ***Not necessarily.*** Unless such assumptions are verified, the interview proceeds from a distorted perspective (refer to role played experience notes on the board).

The following guidelines are reiterated to guard against perpetuating incorrect assumptions:

1) Be aware of what your assumptions are in the interview;

2) don't take them too seriously (suspend judgment);

3) check them out, by asking a well-timed question, using a format similar to the example below.

"Mr. S., your flushed face and the fact that you are taking antabuse (feedback) make it appear that you have been drinking (assumption). Is that right?" (checking out).

In most cases this kind of inquiry will set the record straight, and the interview can proceed on a more straightforward basis.

The purpose of this exercise and lecturette is to highlight the importance of the process of initial interviews as being equally as important as its content for assessment purposes. (The trainer should note that Appendix B, page III-41, contains additional material and exercises regarding the exploration of attitudes. If the trainer wishes to pursue this topic further with participants, the use of the materials in Appendix B is recommended.)

The trainer should note that the material for this activity is covered in the Participant's Manual, pages III-13 to III-17.

The trainer continues by telling participants that they are going to observe three or four very brief (2-4 minutes each) vignettes of beginning interviews. The purpose of each role play is to promote the discussion of relevant key points through observation.

(*Note:* the trainer must present some poor examples of conducting an interview i.e., must conduct the interview so that participants can generate an explanation of what is wrong and how to correct it. Two trainers should conduct the interview so that the key points noted on page are covered. This will mean that, as points are raised in discussion of one role play, the participants must "play" the next one to raise the issues that were not previously discussed. Usually two or three vignettes are required.)

The trainer should role play the first vignette for two or three minutes, then ask participants to discuss the vignette through answering the following two questions:

1) What factors or issues should have been considered by the interviewer in order to ensure the most effective assessment possible in beginning this initial interview?

2) How did these factors or issues influence the assessment?

Once four or five of the key points have been discussed, the trainer should play another vignette (leaving a list on the flipchart paper of the points covered).

The trainer should refer to the list of topics covered as they play the next vignette in order to ensure that they structure it to bring out additional points. Discuss the vignette and repeat this procedure until all points have been covered. (see below)

Conclude by introducing Activity B.

Key Points

1) The presenting problem:

    (a) is the client in crisis?

    (b) referral or self-referral?

    (c) voluntary or involuntary?

    (d) precipitating factors?

2) The client's perspectives and values:

    (a) client's perceptions of alcohol use, attitudes towards change;

    (b) client's perception of the problem(s);

    (c) client's value system.

3) The counsellor's perspective and values:

    (a) contraindications for you (or your agency's) involvement;

    (b) counsellor attitudes/values/practices;

    (c) orientation to the agency, assessment and treatment.

NOTE: It is imperative that these key points be explored in a manner conducive to the development of the client/counsellor relationship.

ACTIVITY B

CASE STUDY

Time required	50 minutes
Format	Large group discussion and small group exercise
Supportive materials	– Flipchart/blackboard – handouts on Life Areas (page III-XX) – case study, Appendix C and ASIST (Page III-44 in Participant's Manual) – felt pens/chalk

Learning objectives At the conclusion of this module, participants should be able to:

(a) describe four major principles of assessment;

(b) describe the major impact of alcohol abuse on the human body;

(c) understand signs and symptoms of alcohol abuse;

(d) identify 10 major content areas of a BASIC COMPREHENSIVE CLIENT ASSESSMENT.

Instructions For Training Activity B

The trainer should begin by noting that background reading for this exercise is on pages III-13 to III-17 of the Participant's Manual, and that this material should have been read by participants prior to the beginning of this session. It will be reviewed during this 50-minute time slot in the program through discussion and application to case study material. For the purposes of this program, the major emphasis will be on the CONTENT AREAS of the basic comprehensive assessment. The PRINCIPLES material will be reviewed for the perspective that it can bring to the initial interview process in putting it in the overall community treatment system. The GUIDELINES AND SIGNS AND SYMPTOMS are connected directly with the alcohol use content area.

(*Note:* trainers should be aware that different aspects of this material may be emphasized and different components given greater weight depending upon the target audience that the material is being presented to and the objectives of the presentation. A list of key points is included for the trainer to refer to on page III-20. These should be covered during the discussion of the case study.)

The trainer should introduce the exercise by dividing the group into dyads. Before they disperse, hand out the case study (Appendix C) and the ASIST (page III-44 in Participant's Manual). Tell participants that, once in their dyads, they are to read the case study and skim the assessment instrument to decide what is known about the client in the case and what additional information they would like to know. They are to make a brief summary of this for discussion in the large group in about 30 minutes.

Emphasize that the object is not to gain an in-depth knowledge of the instruments, or of the client, but rather to gain a basic familiarization with the instrument (the ASIST). Allow approximately 30 minutes for the work in the dyads, and about 20 minutes for large group discussion.

Break the group into dyads and circulate to ensure that people understand the assignment.

After approximately 30 minutes, reconvene the dyads into the large group. Begin the discussion of the case study by handing out the life areas diagram (page III-23) and stating that, as the case study is discussed, participants are to summarize in point form, information about the case study client (Mr. B. Neign) on this diagram.

Lead a general discussion for about 20 minutes where participants record the known information on the life areas diagram. The trainer should attempt to make the material on this page under key points connect with the discussion of specific assessment facts that participants raise.

The point should be reiterated (and the trainer should not lose sight of the fact) that the intention of this exercise is to gain a basic familiarity with the ASIST instrument and the life areas diagram. Conclude by introducing module 3.

Key points

1) Principles

    (a) systems principles

    (b) functional principles

    (c) training principles

    (d) community development principles

2) Guidelines for understanding the impact of alcohol abuse:

    (a) short-term

    (b) long-term

3) Signs and symptoms:

    (a) suspicious

    (b) probable

    (c) certain

4) Major content areas of the ASIST

    (a) identifying information

    (b) alcohol use

    (c) other drug use

    (d) health

    (e) family/marital

    (f) education/employment/financial

    (g) leisure

    (h) legal

EDUCATION

MARRIAGE

HEALTH

WORK

LEISURE

FAMILY

CULTURE

ECONOMIC

SIGNIFICANT
OTHERS

LEGAL
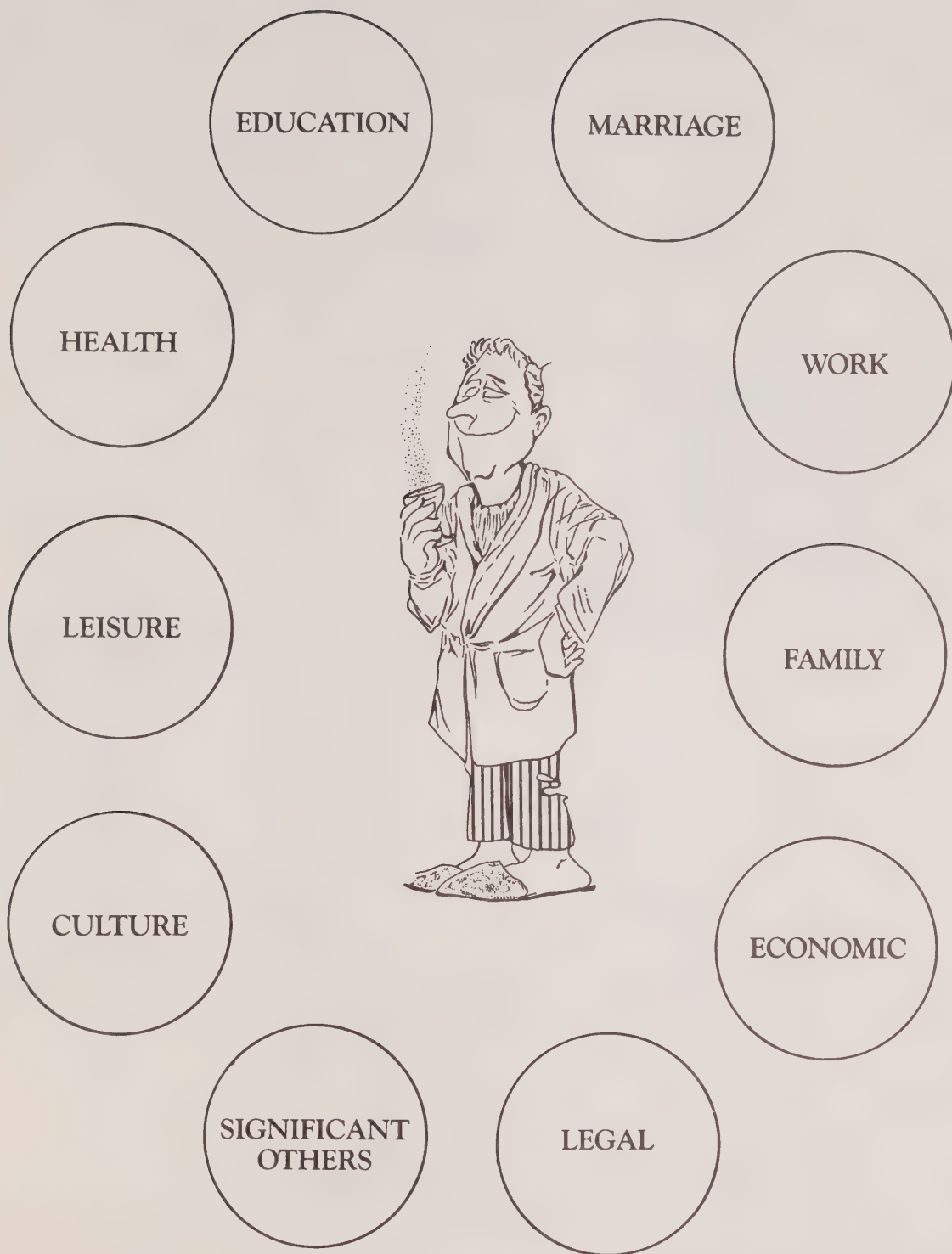
LIFE AREAS

Module 3: SIMULATION

DEMONSTRATE:
the use of basic
communication skills
and practical concepts
in the exploration of one
life area.
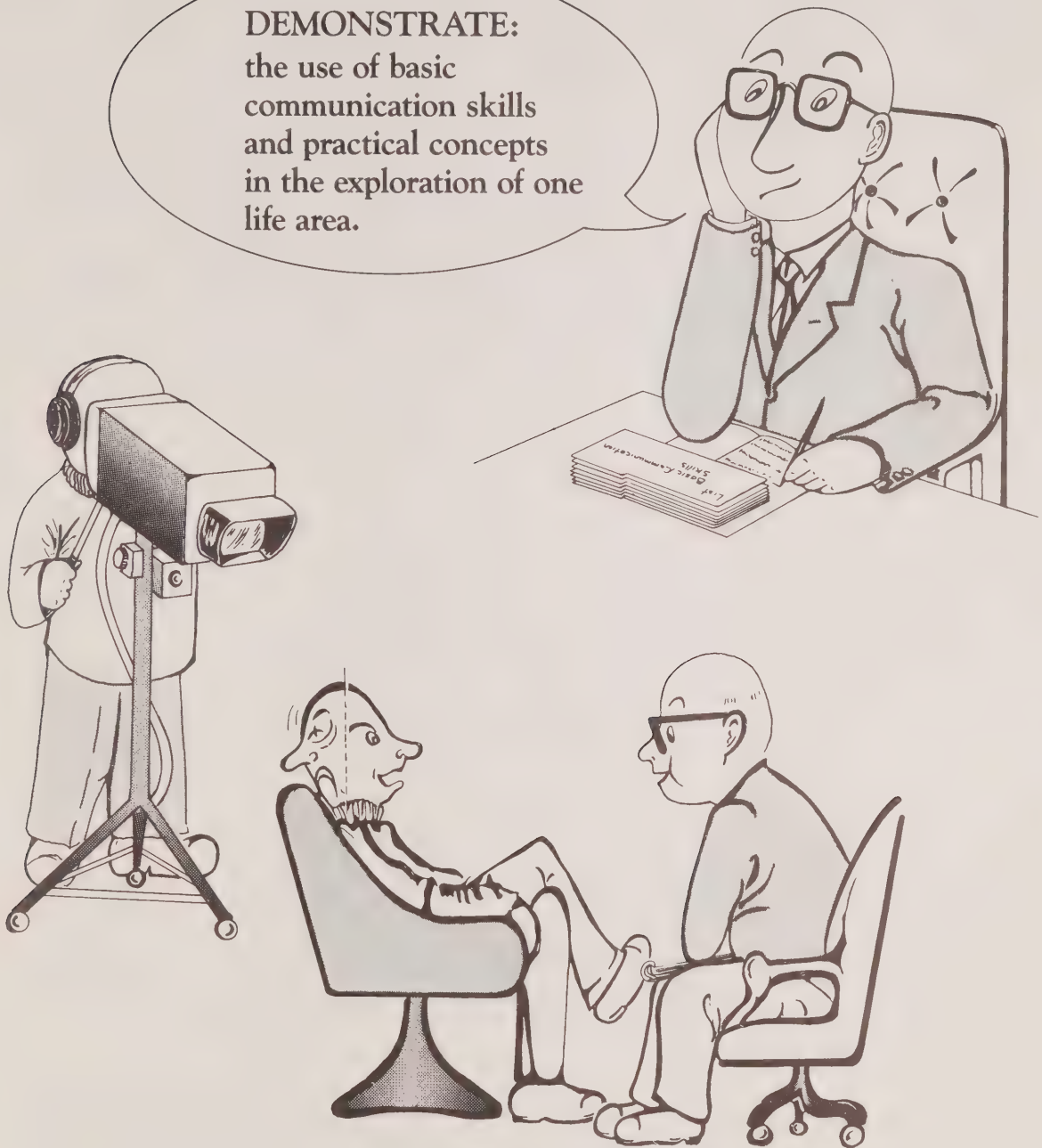
Module 3: SIMULATION

OVERVIEW OF MODULE 3: SIMULATION

Time required	1 3/4 hours are required to complete Activities A and B.
Format	large group discussion and small group practice.
Supportive materials	– Videotape, playback unit and monitor. – Appendix D, page III-54: optional.
Learning objective	At the conclusion of this module, participants should be able to integrate the material of the Practical Drug Concepts Unit with Basic Communication Skills and demonstrate these in a simulated initial interview situation.

ACTIVITY A

VIDEO DEMONSTRATION

Time required	45 minutes
Format	Large group – discussion
Supportive materials	– Video playback unit and monitor and materials videotape. *
Learning objectives	To have participants begin to integrate and understand the relevance of the practical drug concepts knowledge and communication skills to the assessment process.

Instructions For Training Activity A

Before attempting to use the videotape, the trainer must preview it several times in order to be thoroughly familiar with its content. As well, the trainer must isolate several excellent instances in the tape that are particularly good demonstrations of how to begin an interview, how to use excellent Communication/Counselling Skills and how to use Practical Drug Concepts knowledge in interview situations.

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* "Initial Interview" (19 1/2 minutes), available for purchase from the Addiction Research Foundation of Ontario.

TRAINER'S NOTES

The trainer should begin by taking three or four minutes to emphasize that this demonstration of an initial interview pulls together material from the previous two Units. The trainer should ask participants to make notes of questions and observations that they wish to discuss as the tape is being played. The trainer should state that the tape will be played in two parts; the first part will cover the material discussed under "beginning the initial interview" (see key points page III-20). This first part will also stress the use of COUNSELLING/COMMUNICATION SKILLS as in Unit I. The second part will cover the body of the assessment material discussed throughout this Unit and will incorporate both PRACTICAL DRUG CONCEPTS KNOWLEDGE AND COUNSELLING/ COMMUNICATION SKILLS.

Having previewed the tape, the trainer should run the tape through to the point where he is satisfied that the material related to beginning the initial interview has been demonstrated. The trainer should then begin the discussion of the tape through asking participants to describe what was done well. (See key points page III-20). Discuss questions that participants have regarding this segment. This segment of the tape should take approximately 15 minutes to play and discuss.

Play the remainder of the tape and remind participants to make notes as they observe. This segment will take approximately 30 minutes to play and discuss. Trainers should make efforts to point out excellent examples of the use of Communication/ Counselling Skills and the application of Practical Drug Concepts knowledge.

Trainers may want to play the tape through, then rewind to illustrate certain points, or they may wish to stop the tape to focus the attention of participants on specific points. Experience with this module will allow trainers to develop their preference.

Conclude by introducing the next practice session where they will have the opportunity to model some of the interviewing skills they have seen demonstrated.

NOTE: If a live role play demonstration is used rather than the videotape, the trainer conducting the role play must ensure that their demonstration is a clear example of the use of COMMU-NICATION/COUNSELLING SKILLS and the application of PRACTICAL DRUG CONCEPTS knowledge. It is suggested that trainers follow the same format, i.e., break after the "beginning the initial interview" phase and discuss this before moving on. As a cautionary note, it is not usually too good to role play beyond a 10-minute period without involving participants in some discussion.

ACTIVITY B

PRACTICE

Time required   60 minutes

Format   Small group – practice

Supportive materials   Appendix D (page III-54) optional and

Learning objectives   At the conclusion of this session, participants should be able to demonstrate the use of basic communication skills and practical drug concepts knowledge in a structured simulation exercise.

Instructions For Training Activity B

It is suggested that the trainer review the concept of feedback (Unit I Appendix D) as well as a method for dividing the group into triads (Unit I Appendix C). At the outset, the trainer should take two or three minutes to highlight "feedback" issues. The group should be divided into triads with the roles of client, interviewer and observer assigned to each triad. Mention that each person is to play each role at least once. The observer is to act as timekeeper and is to keep each role play to approximately 10 minutes. Allow about 10 minutes for discussion of each role play. The trainer(s) should circulate among groups to observe and help as required. Trainers may wish to use the sample roles provided in appendix D, page III-54. It is advised, however, that participants should create a client role to play.

A suggested variation of this practice is to involve each trainer in playing the client role. Divide the participants into the same number of groups as there are trainers and assign participants the responsibility to explore one or two life areas from the ASIST instrument. Once in the small groups, the trainer plays a client and each participant takes 10 minutes to explore his/her life area and discuss it with the group. Continue this until all participants have had the opportunity to practise and to be given feedback. Each participant is to act as an observer while others are interviewing. This process can be very exciting and is an excellent variation on the "role play" theme.

Conclude by reconvening in the large group and introducing the final module.

Module 4: ASSESSMENT DOCUMENTATION
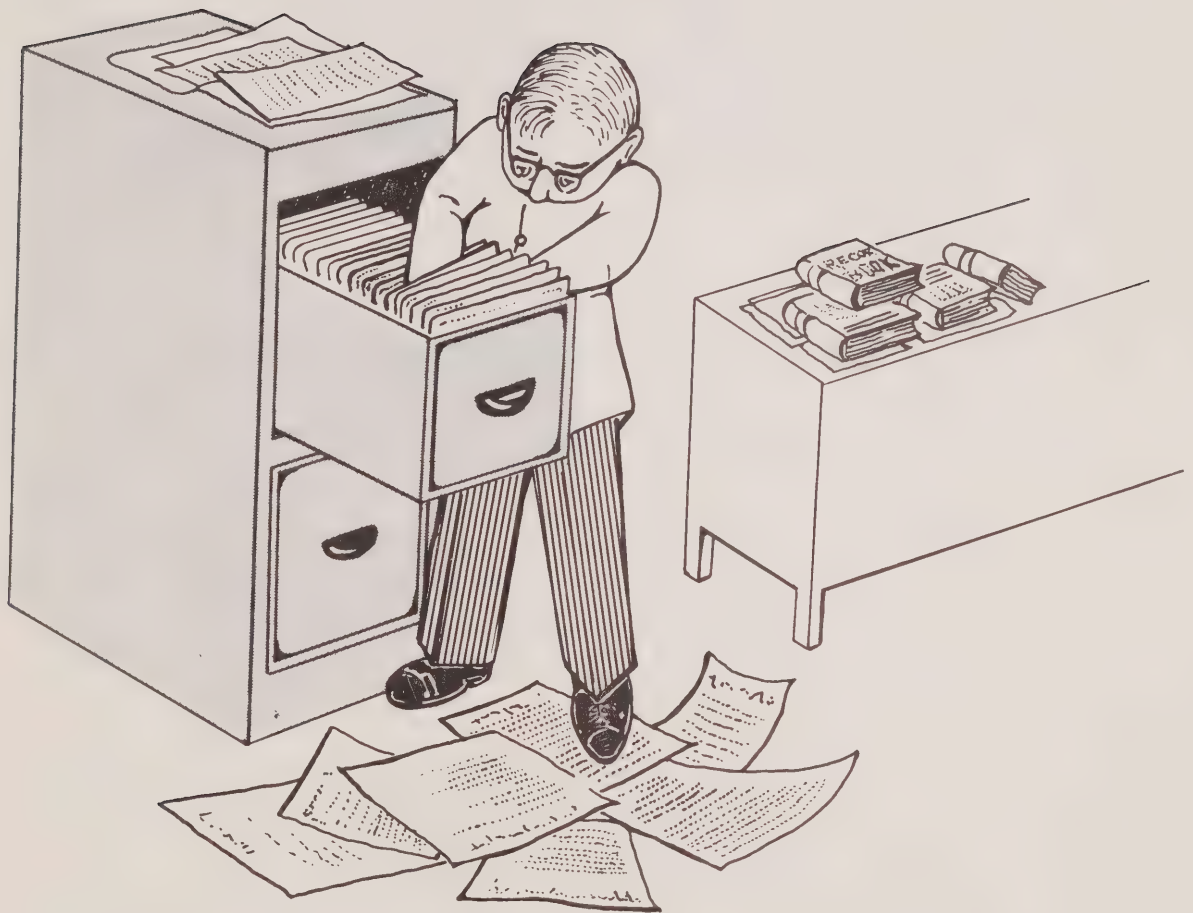
Module 4: ASSESSMENT DOCUMENTATION

OVERVIEW OF MODULE 4:
ASSESSMENT DOCUMENTATION

Time required	Approximately 60 minutes to complete Activities A and B.
Format	Large group discussion and lecturette.
Supportive materials	– Overhead projector and transparencies, handouts pages III-34 to III-36 and flipchart. – felt pens
Learning objectives	At the conclusion of this module, participants should understand the relevance of assessment to the counselling process, be able to demonstrate how to conduct an initial interview and to complete and maintain appropriate records related to assessment. This should promote closure to the Unit and the day.

ACTIVITY A

RECORDS

Time required	30 minutes
Format	Large group lecturette and discussion
Supportive materials	– Overhead projector, transparencies materials and/or handouts of material, pages III-34 to III-36, flipchart. – felt pens
Learning objectives	At the conclusion of this session, participants should be able to demonstrate an understanding of the definition, purposes, constraints, contents, and ideal characteristics related to documenting client records.

Instructions For Training Activity A

It is suggested that the trainer make transparencies of the material on pages III-34 to III-36 as well as handouts. The trainer should begin this 30-minute discussion by asking how many of the participants like record keeping (usually it is the bane of most clinicians).

The trainer should emphasize that a system can not only make record keeping less burdensome, but can also help change one's perspective on record keeping to make this essential exercise more interesting.

The next step is to take 5 to 10 minutes to have participants define what they mean by "record keeping". During this discussion the trainer should use the overhead and handout on page III-31.

Then, take 10 minutes to have participants brainstorm what the problems (or constraints) are with regard to record keeping (Use transparency and handout page III-34).

Next, the trainer should take 10 to 15 minutes to lead a discussion on the purposes of documentation and brainstorm around what characteristics and information an ideal documentation package would have. (Use transparencies and handouts, pages III-35 to III-36).

Conclude by stating that the final activity will be a general discussion of the material of this Unit.

RECORDS

REFERRAL AND THE PAIN AND PRACTICE OF RECORD KEEPING[19]

DOCUMENTATION IN HUMAN SERVICES-AGENCIES

Key Points/Definition

THE ACT OF PUTTING ON RECORD VALID ACCOUNTS OF ACTIVITIES AND EVENTS RELEVANT TO THE ATTAIN-MENT OF THE AGENCY'S OVERALL GOALS AND SPECIFIC OBJECTIVES.

NOTE: It is suggested that the trainer incorporate content/examples of recording materials from the program(s) with which the participants are affiliated.

FACTORS CONSTRAINING DOCUMENTATION

Key Points

- Time /Resources
- Staff Training
- Staff Motivation
- Confidentiality Issues
- Lack of Resources for Data Analysis
- Legal Concern
- Professional Standards

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[19] The following materials were prepared by Dr. Alan Ogborne for a presentation on documentation at the APT workshop held at the School for Addiction Studies, November 8 – 12, 1982.

Key Points

- – Accountability
- – Continuity of Care to Clients
- – Evaluation of Clinical Practice
- – Communication with Other Agencies
- – Program Monitoring/Evaluation
- – Research – Epidemiological (frequency and extent of problems)
  – Treatment Evaluation
  – Nosological (classification of problems).

WHAT WOULD WE IDEALLY LIKE TO HAVE DOCUMENTED IN THE FILES?

Key Points

- – Client characteristics;
- – referral sources;
- – dates of key events;
- – nature and frequency of client contacts;
- – contacts with other agencies on client's behalf;
- – referral recommendations;
- – outcomes of referrals;
- – services used by client in post-assessment period;
- – client behaviour in post-assessment period;
- – evidence that client consents to transmittal of information to relevant others;
- – evidence that client consents to follow up together with relevant contact information.

CHARACTERISTICS OF IDEAL DOCUMENTATION PACKAGE[20]

Key Points

- – Yields data of known reliability and validity;
- – built-in quality control mechanisms;
- – comprehensive;
- – easy to use;

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[20] Examples of readings for this module might best be obtained at the local level, so as to be relevant to trainee's work situation.

— information requested relevant to needs and inter-
     est of staff and board;

— economical to abstract and analyse;

— respectful of client confidentiality;

— adaptable to local conditions;

— modifiable in light of emerging needs/results/
     procedures;

— backed up with adequate data-analytic resources.

ACTIVITY B

CONCLUDING DISCUSSION

Time required	30 minutes
Format	Large group discussion
Supportive materials	Flipchart felt pens
Learning objective	To ensure that participants understand the material of the Unit and can begin to integrate this material in their practice.

Instructions For Training Activity B

It is suggested that the trainer begin this 30-minute open discussion by asking participants what they found to be most useful about the day (or what they liked the best) and why. This should lead to a discussion of what they found least useful and why. The trainer should take notes for reference with regard to further presentation of the material. Questions and discussions concerning the applica-tion of this material to the participants actual jobs are to be encouraged. Once trainers are familiar with the Unit and have presented it (or modules of it) they may wish to develop a list of "tickler" questions to stimulate discussion from which they can draw if necessary. The intent of the 30 minutes is to clarify issues identified by participants and allow for questions related to the Unit (either content or process) as well as provide closure to the day.

Upon conclusion of the discussion, the trainer should remind participants of any housekeeping items, e.g., additional reading, the time and date of the next training session and conclude the day.

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APPENDIX A

INTRODUCTORY CARD GAME

Each entry is to be typed on a separate index card, and labelled according to which pile it belongs.

DRUNK PILE

In a drunken stupor you have tried to proposition a policewoman – go to LEGAL.

Go to HOSPITAL.

In your intoxicated state, you fall down some stairs and break numerous bones – (game over).

Go see a friend – go to FRIEND.

Go to CLERGY.

Police involvement – go to LEGAL.

Go to DETOX.

Go home and sleep it off (go to HOME).

Go to SCREENING.

CLERGY PILE

Clergy does a good screening job and realizes you have a drinking problem – go to TREATMENT. (2)

Clergyman sends you to screening – go to SCREENING (2)

Clergyman thinks you should go to church more often and give up your immoral ways – you go to DRUNK.

Your clergyman suggests you talk to a doctor – go the HOSPITAL.

Your clergyman suggests you talk to him in the morning – it is now 3:00 a.m. Go to HOME.

FRIEND PILE

Your friend talks to you, but his wife has had it with both of you – you are both kicked out – go to DRUNK. (2)

Your friend doesn't want to talk to you any more and calls the police as you become very angry – go to LEGAL. (2)

Your friend suggests you get medical help – go to HOSPITAL. (2)

Your friend suggests you go for help – go to the SCREENING. (3)

Your friend is a drunk, he doesn't think you have any problems and suggests you buy a case of beer. Together – you get drunk – go to DRUNK. (2)

Your friend is very perceptive and suggests you go for help – go to TREATMENT.

LEGAL PILE

Through a series of events you are sentenced to seek professional help – go to SCREENING. (2)

Police take pity on you and drive you home – go to HOME. (2)

Police take you to detox – go to DETOX. (2)

Police take you to hospital – go to HOSPITAL. (2)

Police suggest you need help – go to SCREENING.

You are put in jail – the key is lost – game over.

Police arrest you for assaulting an officer in your angered state – go to jail – wait five minutes and go to HOME.

Police arrest you for impaired driving on your way home go to jail – wait three minutes and go to SCREENING.

Police take you to hospital – you stagger out after one hour (still untreated) and go home – go to HOME.

Police put you in jail overnight – wait 5 minutes and then go home – go to HOME.

DETOX PILE

You sober up and decide to get help – go to SCREENING. (2)

You leave the detox and continue drinking – go to DRUNK. (2)

You sober up and go home – go to HOME.

Someone suggested that you talk to a clergyman – go to CLERGY.

You meet a friend – go to FRIEND.

You get involved in a fight – go to LEGAL.

TREATMENT PILE

You don't like the interviewer – go to HOME. (2)

Your assessor does an excellent job – a good match – sober at last – congratulations – game over.

You are sent to AA – Congratulations, someone recognizes that you have a problem – game over.

Your assessor only likes to do family therapy. So until you can convince your entire family to come in, go to HOME.

You are assessed as needing family counselling and receive marital and family therapy. Your family brings up the alcohol problem and the therapist and your family help considerably – congratulations – game over.

You show up intoxicated – go to DETOX.

You slipped on the ice coming into the building – your assessor asks if you have been drinking (you have had one drink) – you become angry and leave – go to DRUNK.

You are unsatisfied with treatment – go HOME.

Your assessor doesn't ask about alcohol – you get relaxation training – go HOME – albeit relaxed, but go home.

You show up intoxicated. You are told to make another appointment on another day – go to HOME.

You look awful – your assessor sends you to the hospital – go to HOSPITAL.

SCREENING PILE

You don't like the screener – go HOME. (2)

You are on a waiting list – go HOME and come back tomorrow. (Actually, come back to the pile in three minutes and take the next card.) (2)

You show up intoxicated – go to DETOX. (2)

Your screener does an excellent job – go to TREATMENT. (2)

Your screener forgets to ask about drinking and sends you for dance therapy at the "Y" – go HOME.

Your screener wants you to read a short test – you can't read English – go to HOME.

Your screener sends you for medical help – go to HOSPITAL.

Your screener likes you and becomes your friend – go to FRIEND.

Your screener is frightened of alcoholics but sends you for treatment – go to TREATMENT.

You show up intoxicated and create a disturbance – go to LEGAL.

Your screener is taking a testing course – he wants to do a paper and pencil test. You have lost your glasses. Go HOME to get your old ones – come back to this pile in three minutes.

Your screener doesn't like alcoholics. So you are sent to your family doctor who gives you Valium and sends you home – go to HOME.

HOSPITAL PILE

Hospital sends you to alcohol screening – go to SCREENING. (3)

You get tired waiting at the emergency ward and leave – go to HOME.

You are diagnosed as having psychosclerosis[21] – you don't understand – go to HOME.

You cause a commotion in Emergency – go to LEGAL.

Doctor chastises you for your lack of control – you become angry – go to DRUNK.

You are allowed to dry out in the hospital (thanks to a sympathetic doctor) – go to HOME.

The doctor doesn't like to "diagnose" alcoholism so you are assessed as having "acute ocular analism",[21] you are frightened and decide to have a drink – go to DRUNK.

You get tired waiting at the emergency ward and leave – go to DRUNK.

HOME PILE

You really do think that you need help so you go to SCREENING. (3)

Too much pressure – go to DRUNK. (2)

You become depressed – go to DRUNK.

You are making too much noise – neighbours call the police – go to LEGAL.

You become very ill from drinking – go to HOSPITAL.

You have a terrible argument with your wife and she kicks you out – go to FRIEND.

You are bored so decide to get drunk – go to DRUNK.

At 2:00 a.m. you want help (T.V. station has just shut down for the night) – go see your clergyman, – go to CLERGY.

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[21] a fictitious disease.

APPENDIX B

SURFACING AND EXPLORING ATTITUDES TOWARD ALCOHOLICS
APPROACHES AND TECHNIQUES[22]

PETER FINN
Abt ASSOCIATES INC.

The general public has many inappropriate attitudes towards alcoholism and alcoholics. For example, despite an extensive public information campaign stressing that alcoholism is an illness, not a moral failing, many people now appear to view the disease as an illness and a moral failing. Even health professionals hold many misconceptions about the nature of alcoholism and harbor many negative feelings toward alcoholics.

Attitudes and feelings toward alcoholics can be considered inappropriate if they are based on inaccurate or unproven assumptions about the nature of alcoholism or if they may result in avoidable harm to the alcoholic. Examples of inappropriate attitudes and feelings toward alcoholics include regarding them as:

- sinful or immoral;
- comic;
- frightening;
- weak-willed;
- blameworthy or responsible for their condition;
- incurable;
- unworthy of being helped;
- deserving of punishment.

Some of the many appropriate attitudes toward alcoholics – appropriate because they are based on accurate information regarding the nature of alcoholism and are beneficial (or at least not injurious) to the alcoholic – are viewing them as:

- suffering or in pain;
- victims of a disease or illness[23];
- potentially capable of recovering;
- in need of help;
- entitled to treatment.

These attitudes and feelings are often hidden from the holder or remain unacknowledged in the presence of other people. As a result, they are rarely identified, compared, evaluated, and, when desirable, modified. Even when people know and express how they feel about alcoholics, they may take their opinions for granted and uncritically assume their perceptions are reasonable, constructive, widely shared, and immutable.

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[22] *Journal of Alcohol and Drug Education*, Vol. 24, No. 1, Fall 1978, pp. 58-72.

[23] There is, however, controversy regarding both the scientific accuracy of this view and its therapeutic value.

The following learning activities are designed to help people to surface their attitudes toward alcoholics so that they can then identify and investigate their feelings, either as a silent, internal thought process or, preferably, in discussions with other people whose attitudes have been similarly disclosed.

The activities will have little value for most people unless each is followed by discussion of the attitudes and feelings the exercise has revealed. Merely expressing attitudes and feelings is often not enough if the goal is to foster the development of appropriate attitudes and feelings. Students must also be helped to *recognize* the attitudes, and *evaluate* their appropriateness and utility. To facilitate this process each of the activities provided in this paper includes follow-up discussion topics to be addressed at the conclusion of the exercise.

Instructors and group leaders should also be sensitive to the strong emotions which these activities may arouse in susceptible individuals. For example, if a participant in a role play is becoming over involved in his/her part, the instructor should not hesitate to "cut" the action and move on to a discussion of the simulation or to another role play.

A variety of exercises has been provided from which instructors and group leaders can choose which are most appropriate for the needs of their students, their own teaching capabilities and preferences, and time constraints. Furthermore, it is expected that instructors may want to modify the activities they use to suit the characteristics of their particular audience.

ACTIVITY #1

STUDENTS ROLE PLAY SCENARIOS INVOLVING INTERACTION BETWEEN AN ALCOHOLIC AND A NON-ALCOHOLIC.

Procedure

Have students volunteer to play parts (do not assign them) in role plays in which a family member or an employee is an alcoholic and the other player must decide how to respond to him or her. Sample role profiles are provided at the end of the activity.

Do not let the participants see each other's parts until after the role play or allow the rest of the class or group to read them, either.

If you have difficulty initiating role plays or your students have not engaged in them before, you may want to (1) take one of the role play parts yourself in the first role play, or (2) have the students engage in a written story completion exercise as "practice" (see Activity #6 on how to do this).

Encourage the students after one or two role plays to create their own role profiles for each other to act out.

Follow-up Discussion

After each role play, have the participants read their parts to the class. Then ask the players to discuss the feelings they had while role playing. To facilitate this discussion, ask the participant who played the non-alcoholic role:

1) What feeling did you have toward the alcoholic? Did you try to express these feelings or keep them to yourself? Why? (Do the observers agree that the feelings were voiced or kept suppressed?)

2) How did you feel about these emotions? Did you feel they were healthy? Productive? Inappropriate? Uncontrollable? Embarrassing? Did your emotions change at all during the course of the role play? How? Why?

3) What did you feel your responsibility, if any, was toward the alcoholic? Did you feel capable of exercising that responsibility?

Ask the "alcoholic":

1) What feelings did you have about the other role player? Did you think you understood how he felt about you, or was it difficult to decipher his true feelings?

2) Did you feel his attitudes were helpful or damaging to you? How would you have liked him to feel about you and act toward you?

Conclude each role play by asking the observing students to express how they felt toward the two participants and to evaluate whether their own emotions and attitudes are appropriate ones.

Sample Role Profiles
Set A

Wife

Your husband has been drinking heavily for the past four years, but somehow he manages to keep his job and even perform some of the chores around the house.

He usually doesn't start drinking until noon when he has a few beers at lunch, and then he has a couple more during the course of the afternoon – or at least so you've been told by your neighbour whose husband works for the same company. And he usually comes home with alcohol on his breath, poorly masked, sometimes, with some mouthwash or candy.

When he gets home, he immediately has a few shots of whiskey before dinner, continues with beer during the meal, and then sips on whiskey all evening until bedtime. By the time you go to bed he's pretty bleary eyed and slurring some of his words.

You've tended to ignore his drinking, because it seemed like something many men do. Besides, it hasn't seemed to interfere with his job, so how could he really have a drinking problem?

But recently you read a magazine article which pointed out that most alcoholics do have jobs – and families. In addition, it's become impossible for the two of you to spend time anymore with your friends, because your husband always gets drunk and usually insists on driving home, too. Some of your friends have stopped inviting you over to their houses and have begun to turn down your invitations.

Last night, when you were driving home from a movie, your husband nearly got into a serious accident by running a red light. He'd been drinking all day, and you'd stopped for a few more drinks at the local tavern on the way home. You were really frightened, and worried for the children (who were at home).

You've decided to confront your husband with his problem – for you now realize he is an alcoholic and cannot stop drinking without help. You certainly can't go on living this way.

It's Saturday morning – before he's had anything to drink. The kids are playing outside. You and he are sitting over coffee, planning the day. You decide now is the time to bring up the subject. WHAT DO YOU SAY?

Husband

For the past three or four years, you've been drinking a little more heavily than you used to, because you find that your job makes you tense and alcohol helps you relax. You're grateful that it's available – no pills for you! Without a few drinks in you at night, you have trouble falling asleep, too.

But even though you have a beer or two at lunch and a couple of shots of whiskey before and after dinner, you've made sure you're not drinking too much. It hasn't interfered with your job at all – in fact, only last month the boss gave you a raise.

Sometimes, though, you think your wife feels you're drinking too much, so you try to keep her from seeing you drink, because she will just get worried over nothing. For example, last night on the way home from the movies and after a quick stop at the tavern for a nightcap, you almost got into an accident because another driver went through a red light. Your wife became very upset, telling you to drive more carefully!

You have noticed recently that one or two of your friends have stayed away from you for some reason, but you figure it's because you got a raise at work and they're jealous. You'll just have to make some other friends who earn as much as you do.

It's Saturday morning, now, and the kids are playing outside. You're sitting with your wife over a cup of coffee. It looks as if she has something on her mind. Maybe she's thinking about that close call last night. If she brings it up and complains about your reckless driving, WHAT WILL YOU SAY?

Set B

Supervisor

You have a secretary in your company who has been coming in late to work and missing some days completely. This has been going on for over a year, but she's such a good typist you've ignored it – good typists are hard to come by these days.

However, her immediate boss has already complained several times about her tardiness and absenteeism and suspects it's because she's an alcoholic. He says he's seen her slip out during the late afternoon a few times, and twice he saw her going into the bar down the street.

You've called the secretary in for a talk with you, but you're not quite sure how to go about dealing with the situation since she may deny that she has a drinking problem. Besides, she is such a good worker when she's doing her job. But you clearly have to do something, because her boss isn't going to put up with her action much longer.

You've just ushered her into your office, and she's taken a chair opposite to you. WHAT DO YOU SAY?

Employee

You have been drinking rather heavily for several years now and can't seem to live without alcohol – lots of it. You feel so unhappy unless you've had a few drinks.

But because of your drinking you have had hangovers that prevent you from going to work some days and make you late on others. Some days you can't last until you get off work, so you slip down to the bar a block away during the afternoon for a drink or two.

Your boss has already complained several times to you about your tardiness and absences, and now you've been asked by his supervisor to come in for a talk. You feel you cannot tell your boss or his supervisor why you've been late and absent because you may be fired, and then you'd have no way to support yourself.

You've just been ushered into the supervisor's office and taken a seat opposite to him. If he asks if you have a drinking problem or tells you your tardiness and absences have to stop, WHAT WILL YOU SAY?

ACTIVITY #2

STUDENTS "ABSTAIN" FROM A HIGHLY PRIZED ACTIVITY IN ORDER TO EXPERIENCE SOME OF THE FEELINGS AN ALCOHOLIC MIGHT HAVE.[24]

Procedure

Have each student pick one or two activities he does which he would find very difficult – perhaps impossible – to stop doing. Then have each student agree in a written contract with the rest of the class to forgo the activity for at least a week, but preferably for a month.

It might be more enjoyable and educational for students to experiment with a friend or small group, with each person renouncing the same activity.

Depending on their "passions", students might:

- use no salt or sugar in their food;

- give up cigarettes;

- stop seeing or talking with a close friend;

- not kiss or touch their girlfriend, boyfriend, husband or wife;

- not make or answer any telephone calls;

- get up at 4:00 a.m. every morning (that is, not sleep late);

- stop watching television or listening to the radio;

- give up coffee or another favourite beverage;

- give up a favourite sport or other form of recreation;

- stop chewing gum.

It may be helpful for the students to keep a diary of their behaviour and feelings during the experiment to the class. Students can also consider talking into a tape recorder at the end of each day and playing back excerpts to the class at the conclusion of the experiment.

Follow-up Discussion

After the students have refrained from their activities for at least a week, have the class recount their experiences. Then address the following specific questions:

1) How many of you succeeded in refraining from your activities for the entire period of time stipulated in your "contracts"? How soon did those who failed give in? How do those of you who failed feel about yourselves? Disappointed? Angry? Indifferent? Relieved? How do those of you who succeeded feel about those who failed? Superior? Sympathetic? Resentful? Neutral?

2) What did it feel like not to be doing the activity? Did you miss it badly? Did you get angry? Frightened? Miserable? Grouchy? Bored? Frustrated?

3) Did your relationships with other people change? For example, did you avoid certain people, or people in general, spend more time than usual with certain people, or with people in general, or relate to people differently – for example, argue with them more than normally?

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[24] This activity has been adapted from a version published by the author "Empathizing With Addicts," in *Health Education*, Vol. 9(1), March/April 1978.

4) Did talking or being with other students who were refraining from the same activity as you (or a different activity) help you to resist the temptation to give in? Did you ask for – and get – help from other people in your attempts to forgo the activity? How did they respond? How would you have liked them to respond?

5) Did other people change their behaviour, attitudes or feelings toward you as a result of your experiment? How did you feel about and react to their changed perceptions or actions?

6) Did you start doing things that you don't usually do, like forget things, become less observant, overeat, or develop physical symptoms such as headaches, stomachaches, tics, loss of appetite, insomnia, or unusual fatigue?

7) Did your other activities change at all – for example, did you compensate for the lack of your "forbidden" activity by participating more in some other pursuit? Did the substitute activity help to take your mind off the thing you wanted to do? Did your efforts at compensation affect any of the people around you?

8) Were you confronted with the opportunity to "lapse", and did your willpower diminish in the presence of the forbidden activity or object? Were other people considerate in not mentioning the activity or substance, or helpful in suggesting a substitute?

9) Did you go out of your way to avoid the activity or substance, or things that might remind you of it? Did your avoidance behaviour help reduce your craving? Did your efforts affect your relations with other people or alter their attitudes toward you?

10) Did you "cheat" at all? If so, did you try to engage in your activity just a little and find you couldn't resist resuming it completely? Did you bother to hide your lapses from other people? If so, did anyone catch you cheating? How did they react? How did you feel about being discovered?

11) When you finally did go back to the activity, how did it feel? Did you try to "make up for lost time"?

After the class has explored the issues related to these questions, students can discuss how their actions and feelings might be similar to those of an alcoholic. The group should also consider how its experiences may have been different from those of compulsive drinkers. For example, the students know that they could resume their highly prized activity with impunity at the end of the test period, while an alcoholic who has stopped drinking knows that to revert to his former behaviour is to court disaster.

Students may also erroneously conclude, based on their own success in resisting temptation, that alcoholics should likewise be able with relative ease to forego their self-destructive practices, when the students' experiences may have misled them in this regard because their own craving was a comparatively mild one and one made even more bearable by the realization that it was only temporary.

Finally, focus specifically on how the students feel about alcoholics. Do they feel the same way about alcoholics as they felt about themselves during the experiment? Should they? Did they gain any new insights into what it feels like to be an alcoholic and how alcoholics can best be helped to shake off their addiction?

ACTIVITY #3

STUDENTS DISCUSS IN SMALL GROUPS WHETHER THEY WOULD GIVE A PANHANDLER A QUARTER.

Procedure

Have the students write how they would respond to the following scenario:

You are walking down Washington Street, and a panhandler with alcohol on his breath stops you and asks for a quarter. DO YOU GIVE IT TO HIM? Why or why not? Justify your response.[25]

Then break the class into small groups and instruct them to discuss and agree on the following issues:

1) Should they give the panhandler the money? Why or why not?

2) How do they feel about the panhandler?

3) Would they give the panhandler the money if he did not have alcohol on his breath? Why or why not?

4) Would they give the panhandler a dollar if asked for it? Why or why not?

Follow-up Discussion

Have each group present its conclusions to the class and record on a blackboard or flipchart the different attitudes and feelings about the panhandler which were expressed. Have the students evaluate the appropriateness of each attitude.

Relate the issue of giving a panhandler a handout to the controversy over what role social institutions – welfare offices, hospitals, law enforcement agencies – should play with regard to alcoholics. Should money be provided to alcoholics with no strings attached? With certain conditions? Which ones? What other actions, if any, should society take with regard to alcoholics? What do the students' opinions on these social issues seem to indicate about their attitudes and feelings toward alcoholics as people?

ACTIVITY #4

AS A VARIATION ON THE PREVIOUS ACTIVITY, STUDENTS CAN DECIDE HOW DIFFERENT TYPES OF PEOPLE MIGHT RESPOND TO A PANHANDLER'S REQUEST FOR MONEY.

Procedure

Distribute to the students two or more of the descriptions provided below of different people being importuned for money by panhandlers. Ask the class to consider in small groups:

1) whether the accosted person would give the money and why or why not;

2) how the accosted person would feel about the panhandler asking him or her for the money;

3) why the students think that is how the accosted person would feel.

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[25] Be sure to point out at the end of the activity that only a minority of people on skid row are alcoholics, and only a small minority of alcoholics (perhaps 3 to 5%) are on skid row.

Follow-up Discussion

Have each group report its conclusions to the class and then discuss why different people might respond differently to a panhandler. Would these same people respond differently to an alcoholic in the family? What determines how people feel about alcoholics? Are ethnicity, age, social class, occupation, or drinking habits and experience factors? If so, how do they exert their influence? What role, if any, do family background, previous contacts with alcoholics, and peer pressure play in shaping attitudes toward alcoholics?

- A gentleman dressed in a tuxedo has just come out of a supper club and is waiting for a taxi. He has short, dark hair and stands very erect with a calm, confident air. A panhandler with liquor on his breath walks by and says, "Say, buddy, can you spare a quarter?" How does the gentleman *respond*? What does he *feel* toward the panhandler? What is he *thinking*?

- A young woman is on the bus on the way to city hospital. As she walks to the emergency ward entrance, a panhandler with alcohol on his breath goes up to her and says, "Say, lady, can you spare a quarter?" How does she *respond*? What does she *feel* toward the panhandler? What is she *thinking*?

- A young man wearing a construction worker's helmet is having his lunch at an urban renewal site. He is dressed in a T-shirt and has bulging muscles showing below his short sleeves. He is drinking a beer with his liverwurst sandwich. A panhandler with alcohol on his breath walks by and says, "Say, buddy, can you spare a quarter?" How does the worker *respond*? What does he *feel* toward the panhandler? What is he *thinking*?

- An elderly woman living in a project for the aged is walking down to the local grocery store for milk and bread when a panhandler with alcohol on his breath walks up to her and says, "Say, lady, can you spare a quarter?" How does the woman *respond*? What does she *feel* toward the panhandler? What is she *thinking*?

- A young man, dressed in bellbottom trousers and wearing beads over a bright blue sports shirt, is walking out of a coffee shop in the early evening. He is with a girlfriend who is wearing a halter, blue jeans, and sandals. They are both a little high on marijuana. As they walk to his second-hand green and orange Volkswagen van, a panhandler with alcohol on his breath approaches them and asks, "Say kids, can you spare a quarter?" How do they *respond*? How do they *feel* toward the panhandler? What are they *thinking*?

You and your students can create new scenarios by altering the accosted person's apparent occupation, hair style, age, sex, clothing(s), companion(s), place he or she is leaving or entering, and immediately preceding activity.

ACTIVITY #5

STUDENTS ROLE PLAY PARENTS CONCERNED ABOUT A SON OR DAUGHTER'S FRIENDSHIP WITH THE CHILD OF AN ALCOHOLIC.

Procedure

Break the students into pairs and give each student in each pair a role profile (child or parent) from among those supplied at the end of the activity or ones developed by you. Have each pair of students role play its scenario by itself. Circulate around the room, listening in on the various conversations. Stimulate discussion where necessary.

Follow-up Discussion

Have each pair present its solution or cause for its deadlock to the class. Have one or two pairs volunteer to reenact their role plays in front of the class.

Conclude the activity by asking the students to discuss:

1) how they feel about the alcoholics they portrayed in their parts;

2) what attitudes toward alcoholics were revealed during their role plays;

3) why different students might have experienced different feelings and expressed different attitudes toward alcoholics;

4) which of the attitudes that were expressed are appropriate and inappropriate and why.

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Sample Role Profiles

Set A

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Parent

Whenever you pick up your son from Little League practice or games, you see him talking with Richard Smith, another player. The few times you've come early, you've noticed that they sit together on the bench and, during practice, they talk together as they catch fly balls.

Richard's father, old Joe Smith, is, as everyone in the town knows, an alcoholic. Every few months he and his wife have a terrific fight that's heard all over their neighbourhood. One of the guys at the office lives next door to the Smiths and fills you in on all the details.

You've never met Richard, but you know that one of his two older brothers has already been arrested twice for drunk driving.

You're afraid your son may get some bad ideas from Richard, and he never tells you what he and Dick talk about, even though you've tried to find out. Above all, you don't want their friendship to grow into something more serious.

It's dinner time now and you and your wife (husband) are at the table with your son. You feel now is the time to raise the subject. WHAT DO YOU SAY?

Son

While playing Little League baseball, you have become friendly with Richard Smith, another outfielder. He's a great kid and an excellent ball player. He tells really funny stories about some of the wild parties he hears about from his older brothers and other exciting things they've done.

You know from gossip that Richard's father is an alcoholic – but Richard has told you, too; it's nothing he tries to hide. But because his father is an alcoholic, it makes Richard seem a little more interesting to you, since your father is a very quiet man. You wonder what it's like having a father who gets drunk and fights with his wife.

Yesterday, during the game, Richard told you his father was going to take him to the Blue Jays game on Sunday and invited you to join them. You don't usually get a chance to go to a big league game – especially one between the Expos and the Blue Jays – and you desperately want to go. Secretly, you're also very curious to meet Richard's father.

It's dinner time now at your home, and you figure you had better tell your parents where you're going on Sunday. You wonder if they'll object. WHAT DO YOU SAY?

Set B

Parent

Your 16-year-old daughter has started dating Jack Doe (who is 17) and seems to be growing fond of him. You are terribly concerned about this because Jack's father and older brother are both alcoholics. Mr. Doe has been to the hospital more than once to "dry out" – and the oldest son seems to be following in his footsteps. You feel Jack will probably end up the same way.

You've met Jack a few times when he's come to pick up your daughter, and you haven't particularly liked him. But you really can't say what it is about him you don't like.

Your daughter has just now come in an hour late from a date with Jack. As you are about to scold her for being late (after all, it's nearly one in the morning), you notice her eyes are a little watery and you smell beer on her breath! This looks like just the chance you've been waiting for to tell her she has to stop seeing Jack. WHAT DO YOU SAY?

Daughter

For several weeks now you have been dating Jack Doe, a classmate at school. You know that his father and older brother are alcoholics, but you feel Jack is different. Sure, he drinks, but no more than any other of the kids his age. (He's 17 and you're 16.) Besides, he's really nice and he needs someone like you who will treat him with respect.

Just now you've come home from a late date with him. You went to the movies with some other kids, and after the show you all went over to one guy's house because his parents were away for the weekend.

Whenever you've been with Jack in the past and there's been beer around, you've never drunk very much, just a couple of beers – enough to get a little high. Jack usually has a couple, too.

Now it's nearly 1 a.m. as you come into the house, and, sure enough there's your father (mother) waiting up for you. And you promised you'd be home by midnight! He (she) is probably going to notice you've been drinking and cause a scene, when all you've had is two beers all evening.

If he (she) does get angry, WHAT WILL YOU SAY?

ACTIVITY #6

AS A VARIATON ON ACTIVITIES #1 AND #5 (THE ROLE PLAY ACTIVITIES), STUDENTS COMPLETE UNFINISHED STORIES FOCUSING ON RELATIONSHIPS BETWEEN AN ALCOHOLIC AND A NON-ALCOHOLIC.

Procedure

You or your students can rewrite the role profiles in activities #1 and #5, turning them into short stories which have a missing part – an ending, middle, or beginning. An incomplete story is provided as an illustration of this approach at the end of the activity.

Have the students individually or in small groups write what they believe happened in the omitted part of the story or stories.

After the students have supplied the missing section, break the class into small groups. Have each group read the completions written by all its members. Then have each member of each group explain to the other students in his group why he thought the plot evolved as it did in his written completion. Instruct the groups to try to reach a consensus on what they think

the most *plausible* ending (middle, beginning) would be for the story. Finally, have a spokesperson from each group present his group's conclusions to the rest of the class.

Follow-up Discussion

Concentrate your follow-up discussion on what attitudes and feelings (such as disgust, fear, concern, indifference, anger, pity) were expressed toward the alcoholic in the story completions. List these attitudes on a blackboard or flipchart and have the class evaluate their appropriateness.

Two other follow-up activities you can conduct are described below:

1) Have the students individually or in small groups write a short story of their own and then select a crucial part to omit. Have the students or groups exchange stories and fill in the missing part of the story they were given. Then bring the original authors and "completers" together to compare the inserted ending (middle, beginning) with what the author had written for the missing section. Students then identify, discuss, and evaluate the attitudes toward alcoholics that were expressed in the two different versions and seek to resolve any discrepancies in attitudes revealed in two completions.

2) You or your students can develop incomplete stories which focus on *other* illnesses or handicaps, such as heart disease, cancer, paralysis, or blindness. Have the students complete these stories and compare the attitudes their completed portions express toward people with other illnesses and handicaps with the attitudes the class expressed in their previous story completion toward alcoholics. If there are any differences, what might account for them? Should alcoholics be regarded and treated in the same manner as people with other illnesses or handicaps?

Sample: Unfinished Story

Mary was 12 years old and excited to be going home with her new friend Joan for a visit after school. When they entered Joan's house, Joan's mother was in the living room watching television and drinking orange juice. She got up and introduced herself to Mary, but she seemed to be just a bit unsteady and just a bit too friendly.

But Mary hardly had a chance to think about it, because Joan hurried her upstairs, where they spent the next hour in Joan's room chatting and looking through some of Joan's photographs of her past summer vacations.

Mary and Joan saw much of each other at school after that, but it wasn't until two weeks later that Mary went with Joan for a second visit. Joan's mother was in the living room again watching television and drinking orange juice. But when she saw Joan, she quickly snapped, "Who's this?" – meaning Mary. "I thought I told you to clean up the dishes in the sink this afternoon." Mary immediately offered to help clean up, and the two girls fled to the kitchen, eager to escape Joan's mother.

As they worked, Joan thanked Mary for helping her, but she couldn't stay calm. She began to cry and said, "Now you know. My mother is a drunk – she drinks vodka and orange juice all day long." Mary really didn't know what to say. They kept on doing the dishes in silence. When they finished, Mary left for home, telling Joan she would see her in school the next day.

Mary was so upset by the incident with Joan's mother that she decided to talk to her own mother about it. "It's just as well," her mother said. "I don't want you getting mixed up with alcoholics anyway. I'm glad you found out now. You have lots of other friends, so you don't need this girl Joan."

Mary went to her room to think out the problem, Joan needed her, she was sure, and she wanted to help her. Besides, Mary liked spending time with Joan.

Mary decided she had to follow her own beliefs and went to the telephone to call Joan. She invited Joan over for the next afternoon, and was delighted to learn Joan was willing to come.

APPENDIX C

CASE STUDY

(USED WITH EXERCISE TO FAMILIARIZE PARTICIPANTS WITH A BASIC COM-
PREHENSIVE ASSESSMENT INSTRUMENT.)

This is the Case Study of Mr. B. Neign

"B" is a 45-year-old employed male, living in a large Ontario city. He is approximately 5'8"
and has a weight problem – weighing as he says "about 195 pounds". "B" is employed as a
forklift truck operator in a large factory where he has worked for 14 years. He had a very good
work record up until about seven years ago. At that time, he began to drink more heavily – six
to 10 bottles of beer each evening while watching TV which he says is his "exercise". More
recently, he has been going out to a local "topless bar" at lunchtime once or twice a week
having four or five beers at lunch. He has been warned by his supervisor of his drinking and
has twice been assigned to a shipping role for the afternoon as he was "moderately intoxicated"
after lunch and his supervisor refused to let him drive the forklift truck. Only two weeks ago,
he was sent home from work after driving the forklift truck off the shipping platform and on to
the front of the supervisor's new Chev pickup truck. At the time he smelled very strongly of
alcohol and was suspended from work for one week. His employer is negotiating with the
union regarding possible dismissal or reassignment.

Aside from his lunchtime and regular evening drinking, "B" frequently drinks very
heavily on the weekends – stating that he often drinks one or two cases of beer and 20 to 40
ounces of rye. This drinking is usually done with "the boys" around sporting events on TV. He
feels that his drinking is "just like the rest of the guys" and that although he is a heavy drinker,
he isn't a drunk. He blames his forklift accident on outdated equipment and poor brakes on
the machine. "B" feels that his drinking is fairly steady and states that the only time he drinks
for longer periods is on his annual fishing trip with the boys. During his fishing trip he says he
basically stays pretty drunk all week.

"B" is married and has two children, both of whom have left home (ages 17 and 20). He
states that he and his wife argue frequently about his drinking as she feels he spends too much
money on alcohol. Last month, she threatened to move in with their youngest daughter and
leave him. He said that this was the result of an argument where he hit her. "B" says that he
thinks his wife is having an affair as their sex life has been non-existent for the last two years
and both have had previous affairs since being married. When he raises this issue, his wife
repeatedly brings up their poor financial situation since they refinanced their house to buy "B"
a $30,000 boat which he subsequently burned on a fishing trip. The insurance refused to pay
as all four passengers and the boat operator were intoxicated and were responsible for the fire.
She also reminds him frequently of his $500 impaired driving fine which he received during
the last year. His accusations and her dredging up his disasters of the last two years usually
result in violent arguments. She has told him that if he is fired, she is leaving him and suing
for divorce to get some proceeds of the house. She told him that she has already spoken to a
divorce lawyer. "B" said that this last threat was what prompted him to seek help although he
still feels that drinking isn't the problem. "B" states that his father was an alcoholic and that
his brother is certainly one as well. His father died of cirrhosis and he thinks his brother is
living in Vancouver (he hasn't heard from him in four years).

APPENDIX D

SAMPLE ROLES FOR PRACTICE SESSION

MODULE 3

Frank Leigh

- 28 years old.

- Separated, with one child, a girl aged 9.

- Youngest of three children. Sees his two sisters very infrequently (once a year).

- Living on his own in an apartment.

- Laid off at GM in Oshawa three months ago.

- Is having difficulty keeping up his van payments, his apartment rent, and support payments.

- Wife is threatening to take him to court for lack of support.

- Has a second impaired driving charge coming up in two weeks and is very worried about it.

- Frank is a moderately heavy drinker – daily 4 to 8 drinks – mainly beer. Frank weighs 190 pounds and is 6'2" tall.

Beatrice Good

- 30 years old

- Separated with a child under the supervision of the Children's Aid Society.

- Very much wants to have her child back, but has a history of child neglect when she begins drinking heavily.

- Bea has been employed in a variety of positions, primarily as a cashier and bar maid. She has been convicted on two occasions of being a prostitute.

- Currently lives alone and wants to get some kind of manpower retraining to make a new life for herself and her daughter.

- Bea drinks daily – four to six drinks – and goes on binges where she will stay extremely drunk for four or five days. These occur every couple of months.

IV

TREATMENT
PLANNING STRATEGIES
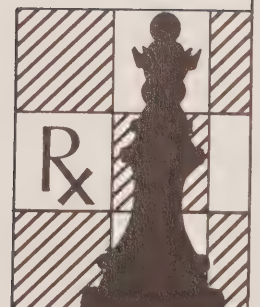
UNIT IV
TREATMENT PLANNING STRATEGIES – TRAINER'S MANUAL

TABLE OF CONTENTS

INTRODUCTORY PERSPECTIVE

Initially, the fundamental objective of counselling clients is to decide what (if any) problems exist and to decide what to do about those problems, i.e., *treatment planning*. This Unit focuses on systematic ways of analysing assessment information to:

1) Describe what major factors are contributing to the problem (biological, environmental, and psychological);

2) Match clients to available treatment resources through a process of negotiation;

3) Prevent and deal with relapse;

4) Provide continuing care and case management.

Although the time allowed is *not* sufficient to master the skills, the Participant's Manual provides source material for continued practice and self-monitoring. Participants should be encouraged to arrange for supervised practice of these skills until they have mastered them sufficiently. Use of this Unit, as with others in this package, should assume that MUCH MORE TIME and PRACTICE are needed to adequately learn the concepts and skills presented. Thus, the need for continued training as discussed in the Introducton to this package.

Before beginning this Unit, trainers must ensure that they have completed the following three preparatory steps:

1) The trainer should have read the training manual and accompanying appendices thoroughly to ensure a sound understanding of content;

2) the trainer should have a dry run with all materials, instructions, and exercises that they are not absolutely familiar with. This will ensure that trainers fully understand the training methodology;

3) all materials and equipment needed should be gathered beforehand and tested to ensure a smooth flowing training session. This is particularly critical with regard to audiovisual equipment (if it is to be used) to ensure knowledge of operation and compatibility of videotapes with playback units.

In addition, it should be noted that there is a sample schedule for this Unit. If trainers choose to use that schedule, they should send out Participant's Manuals well ahead of the training event (e.g., two or three weeks) and ensure that participants receive and read their manuals prior to the event. (It may be advisable to telephone each participant about one week prior to the event to ensure that they have received the material and to remind them to read it.)

If the trainer wishes to expand the time-frame for this Unit, time could be allowed for segments of the manual to be handed out and read during the session time.

A final comment relates to the structure of the Unit. It has been constructed so that it may be used as a whole, or modules may be independently selected for use on their own.

The trainer should ideally be a clinical counsellor with a wide range of intervention experiences to draw upon.

OBJECTIVES

TREATMENT PLANNING STRATEGIES

MODULE 1: FUNCTIONAL ANALYSIS

Goals/Objectives

The goal of this module is to enable participants to better analyse the information obtained in the initial interview/assessment process for treatment planning purposes, through understanding how drug use patterns can be functionally adaptive.

By the end of this module, participants should be able to:

- explain denial as an interaction process;
- describe four levels of drug use (experimental, frequent, intensified, addictive);
- identify major obstacles to stopping drug dependence and vicious circles which perpetuate it;
- analyse common antecedents and consequences associated with drug dependence (physical, psychological, social);
- discuss four theoretical perspectives for perceiving drug use (moral/legal, disease/public health, psychosocial, sociocultural).

MODULE 2: MAJOR MODALITIES

Goals/Objectives

The goal of this module is to briefly describe the purposes, functions, and approaches employed by the major modalities and methods used in the treatment of drug/alcohol dependence. By the end of this module, the participants will be able to:

- list at least five major treatment approaches available to their clients;
- list at least four issues to consider in selecting a treatment approach;
- describe the four general guidelines for designing treatment plans.

MODULE 3: MATCHING

Goals/Objectives

The goal of this module is to make participants aware of the relationship between assessment and treatment planning functions, including plans for continuing care and case management, using available resources.

By the end of this module, the participants will be able to:

- describe the major principles for treatment planning in relation to the assessment process and matching clients to treatment;
- outline the rationale for principles of, and limitations of systematic attempts to match client variables with treatment methods;
- identify the major dimensions on which client treatment matching may be used (psychological, social, physical);
- list the major treatment resources available to their clients;
- identify the purposes, limitations of, and means of accessing those resources.

Goals/Objectives

The goal of this module is to make participants aware of the importance and functional aspects of continuing care in the context of other treatment system functions (assessment/referral and treatment planning).

By the end of this module, participants should be able to:

– explain the role and value of continuing care/management services;

– explain the relevance of, and some approaches to, relapse prevention for treatment planning;

– Design a simulated relapse prevention and response plan.

SAMPLE SCHEDULE
UNIT IV: TREATMENT PLANNING STRATEGIES

SAMPLE TIMES	TIME REQUIRED	TITLE	ACTIVITY/ FORMAT	MATERIALS	PAGE
9:00	35 min.	**Module 1** Functional Analysis	Activity A – Warm-up – small group exercise – large group discussion	"Dependency Checklist" (Figure 14 in Participant's Manual, page IV-63)	IV-13 to IV-16
9:35	60 min.		Activity B – Denial Negotiation & Motivation – large group lecture – triads within large group – large group discussion	"Negotiation Checklist" (Figure 13 in Participant's Manual, page IV-62)	IV-17 to IV-20
		BREAK			
10:50	40 min.		Activity C – Decision Model	– Flipchart/blackboard – chalk/felt pens – overhead projector (optional)	IV-20 to IV-23
11:30	60 min.		Activity D – Diagnostic Perspectives	– flipchart/blackboard – chalk/felt pens – overhead projector (optional)	IV-23 to IV-35
12:30	30 min.	LUNCH			
1:00	60 min.	**Module 2** Major Modalities	Activity A – Treatment Approaches – large group	– flipchart/blackboard – chalk/felt pens – overhead projector (optional)	IV-39 to IV-44
2:00	30 min.	**Module 3** Matching	Activity A – Matching Principles – large group	– flipchart/blackboard – chalk/felt pens	IV-47 to IV-51

SAMPLE TIMES	TIME REQUIRED	TITLE	ACTIVITY/ FORMAT	MATERIALS	PAGE
2:30	30 min.		Activity B – Resources – large group	– flipchart/blackboard – available resources list for local area (prepared by trainer in advance) – felt pens/chalk	IV-51 to IV-52
3:00	15 min.	BREAK			
3:15	30 min.		Activity C – Selection of Treatment – small group – and/or large group	– Selection of Treatment Checklist (Figure 11 in Participant's Manual page IV-49) – Completed Assessment Report – Available Resources (list for local area)	IV-53
3:45	15 min.	**Module 4** Continuing Care/Man-agement	Activity A – Case Management – large group	– flipchart/blackboard – chalk/felt pens	IV-57 to IV-59
4:00	30 min.		Activity B – Relapse – small group – and/or large group exercise – large group discussion	– Relapse Prevention Checklist (Figure 12 in Participant's Manual page IV-60) – Dependency Checklist (filled out in Module 1)	IV-59 to IV-61
4:30	30 min.		Activity C – Relapse Prevention Plan – small group – and/or large group exercise	– Completed Assessment Report Relapse Prevention and Response Plan Checklist (Figure 12, Participant's Manual page IV-60)	IV-62 to IV-63
5:00		ADJOURN			

"Vicious circles" perpetuating drug use
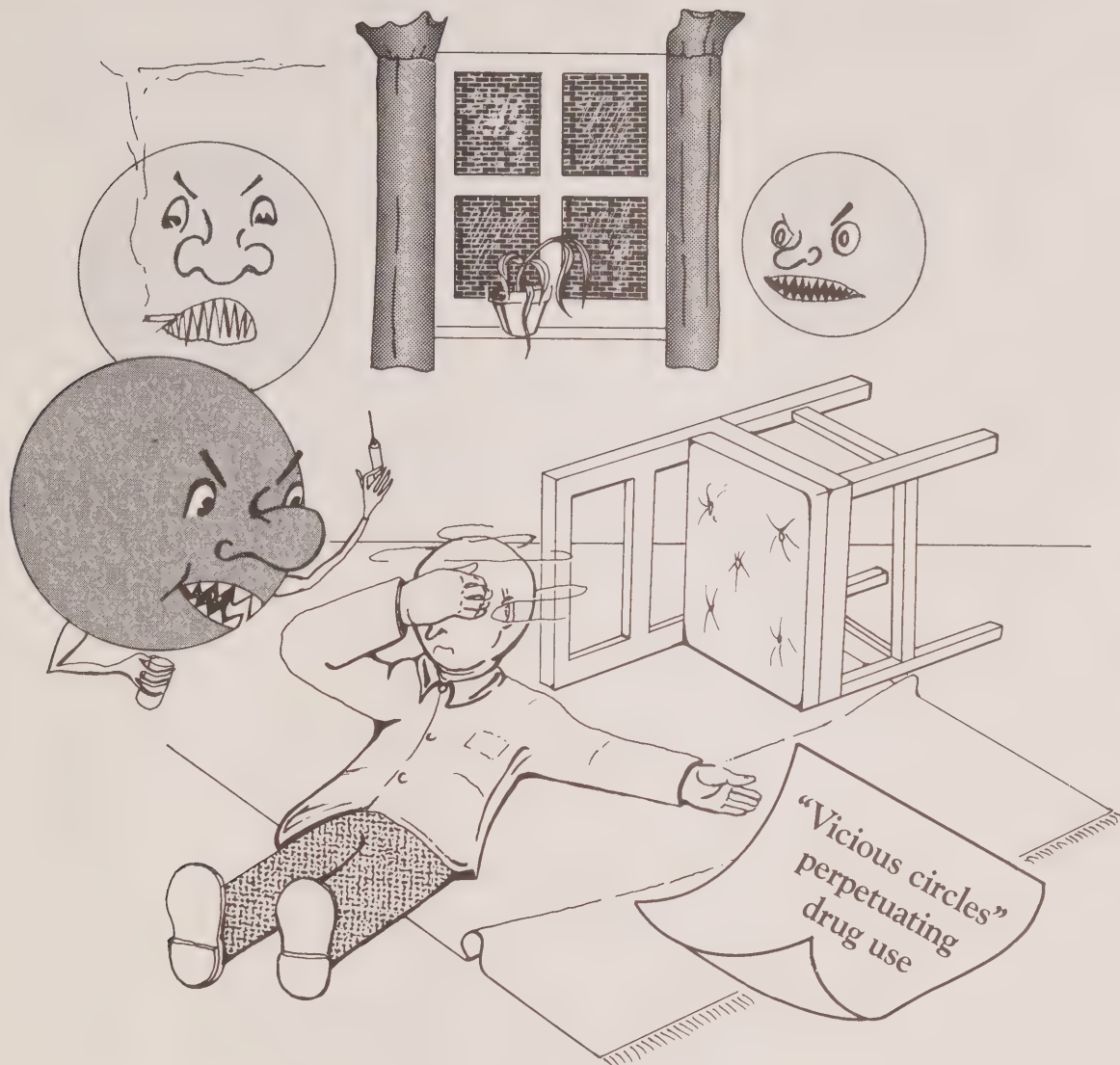
Module 1: FUNCTIONAL ANALYSIS

OVERVIEW OF MODULE 1: FUNCTIONAL ANALYSIS

Time required	195 minutes (3 1/4 hours)
Format	Large group – exercise – lecture – discussion
Supportive materials	– Flipchart/blackboard – felt pens/chalk
Learning objectives	1. To enable participants to specify how particular patterns of drug use are functionally adaptive
	2. To enable participants to apply a functional analysis of assessment information to the design of individualized treatment plans
	3. To orient participants to the total Unit.

ACTIVITY A

WARM-UP

Time required	35 minutes
Format	– small group exercise and discussion
Supportive materials	Dependency Checklist (page IV-63, Participant's Manual)
Learning objective	To enable participants to identify one or more important dependencies in their own lives, so that they are in touch personally with the concept of dependence, and what functions it can serve.

Instructions For Training Activity A

Space requirements:

The space required for this module is a room large enough to accommodate more than one small discussion group or extra rooms for this purpose (4 to 8 per group).

Instructional Sequence:

Begin by reviewing the objectives of Unit IV with the total group.

Explain the sequential flow of this module, highlighting:

– large group introduction to the content;

  — small group warm-up;

  — lecture presentation by the trainer;

  — large group discussion.

Introduce the session as follows:

In this session we'll be concentrating on finding new ways to consider the phenomenon of drug abuse. It is hoped that this effort will allow us to examine some of the inaccurate images and unsound assumptions about substance abuse and use that can impede progress in dealing with problems associated with substance abuse and dependent behaviour.

Let us define discomfort in the very broadest terms, as ranging from a sense of uneasiness to actual, objective, physical symptoms. As a sample of minimum discomfort, let us consider having such habits as reading the comics or watching a morning news program, and then not being able to get the paper or watch TV. For most of us, maximum discomfort might be experienced by giving up cigarettes, coffee, or the daily cocktail.

As a prelude to the small group exercise, let us take a few minutes to consider what our own dependencies are.

Ask each member to tell the group what his minimum and maximum discomfort dependencies are. Stress that they need not reveal their maximum dependencies unless they are comfortable doing so.

Explain the small group activities:

When you break into small groups you will be working with the Dependency Checklist in your manual, page IV-63. You will be ordering some dependencies according to various possible reasons for their existence. You need not respond to every item on the Dependency Checklist, and you are free to assign as many different reasons to each one as you feel is appropriate. Also, feel free to add your own dependency, or not discuss ones which are too personal to reveal.

Divide the large group into small groups (approximately three to seven in each group).

Small Group Discussion

Ask the small groups to complete the Dependency Checklist in five minutes.

Discuss the activities that were listed by participants.

Allow about 20 minutes for this discussion, but try to give each participant who wants to an opportunity to speak.

Return to the large group for the lecture presentation.

The Dependency Checklist

Instructions

For each act that applies to you, put the number of as many reasons as seem appropriate next to the act. Try to remember your initial reasons (and include these) for doing the act, as well as your current reason(s). Even if some acts don't apply, you may fill in reasons if you can imagine yourself doing the act.

Feel free to add items to either side of the list.

When you have completed the checklist, circle three or four items that have at least six reasons assigned to them.

THE DEPENDENCY CHECKLIST

ACT	REASONS
Smoking	1. Makes me feel good.
Drinking coffee/tea	2. Reduces tension.
Having a drink	3. Puts order in my life.
Watching a particular TV show	4. Gives me something that is uniquely mine.
Playing a musical instrument	5. Perks me up.
Making Love	6. Calms me down.
Eating pastry on Sunday morning	7. Provides a change of pace.
Walking the dog	8. Gives me social acceptance.
Going to religious services	9. Gives me a sense of well-being.
Playing a sport	10. Makes me anxious if I don't do it.
Sunbathing	11. Makes me feel guilty if I don't do it.
Cooking dinner	12. Makes me feel "square" if I don't do it.
Not being a parent	13. Makes me feel in control of my life.
Taking a tranquillizer	14. Usually I just have to do it – it is one of life's givens.
Taking vitamins	
Buying a house	
Having a savings account	
Paying each bill the day it comes in	
Not being late	
Buying clothes	
Grocery shopping	
Reading a book	
Having a routine	
Having a place for everything	

The Problem With Drug Abuse

NOTE: The following information should be presented to the large group. While salient points are abstracted here, it is essential that the trainer becomes thoroughly familiar with the participant readings. Although participants might have to read this material, it must not be assumed that they have digested it fully.

Key Points

1) State that in the exercise just completed, we have looked at some fairly common dependencies and tried to understand how they have become important to us.

2) It is important to look at drug use similarly.

3) Substance use varies from person to person and culture to culture. Give examples.

4) Drug use is adaptive behaviour. It serves a function. Effective problem solving requires definition and analysis of how a particular drug use pattern is functionally adaptive.

5) A complex interaction of the drug, the individual, and the culture explains each person's drug use.

6) This understanding of a person's drug use emerges out of, and is combined with, detailed assessment information and knowledge of treatment resources to determine if and how to provide treatment (See pages IV-5 to IV-17 in Participant's Manual).

7) The modules of this Unit cover:

   – Functional Analysis

   – Major Modalities/and Available Resources

   – Matching

   – Continuing Care/Management.

8) The sequence of topics will be: (briefly elaborate on each of those which will be covered)

   – Negotiation

   – Treatment Approaches

   – Matching Principles

   – Resources for Treatment

   – Decision Model

   – Diagnostic Perspectives

   – Case Management

   – Relapse Prevention.

9) Ask the group if they have any questions.

ACTIVITY B

DENIAL, NEGOTIATION AND MOTIVATION

Time required	60 minutes
Format	large group exercise, lecture, discussion
Supportive materials	– Negotiation Checklist (Figure 13, page IV-62 in Participant's Manual) – flipchart/blackboard – chalk/felt pens – case examples (e.g., Appendix C of Unit III)
Learning objectives	1) Enable participants to explain denial as an interaction process.
	2) Enable participants to explain and demonstrate the principles, guidelines and strategies of motivational interviewing.
	3) Enable participants to describe the principles of negotiation and the elements of the negotiation decision model.
	4) Enable participants to identify their strong points and skills which need more work in the areas of negotiation as described in this Unit.

Instructions For Training Activity B

The trainer may want to begin by asking the participants to imagine that they are (individually) a patient in an assessment/treatment planning interview. During the planning portion of the interview the counsellor looks up from the file and states words to the following effect:

> "To come right to the point Mr./Ms. X, you are an alcoholic; you need treatment; you will never be able to drink again."

Ask participants to think about what their emotional and verbal response would be to such a statement.

Write their responses, in point form on the board/flipchart.

Point out that, according to basic social psychology theory, there is a natural tendency to deny the truth of accusatory statements such as the one made above. Note that often counsellors may make such statements (overtly or by implication) without realizing the natural consequences.

This illustrates the fact that denial is an interactive process which normally requires an accusation to bring it about.

Motivational Interviewing[26]

Present the following principles, guidelines and strategies for motivational interviewing. Refer periodically to the possible reaction (listed on the board) to the negative confrontation made in the denial exercise. Point out that motivational interviewing skills (below) can prevent denial and mobilize clients to seek change.

Motivation (like denial) is an interactive process which allows clients to decide what they want to do, and thus get credit fr success as well as failure. To illustrate this, the trainer may want to use the following example.

State: "What would your reaction be if I were to say:

'If you learn something today, it's because I am a good trainer. If you don't learn anything, it is because you are not motivated'."

(Discuss their reaction briefly.)

Note that their negative reactions are similar to an alcohol-dependent client's reactions when they are told that they would improve if they were motivated (Soden, 1985).

Motivation Principles (Miller, 1983) which help direct persons toward change:

1) de-emphasize labels by referring to drug dependence or drug-related problems rather than the addict or alcoholic;

2) emphasize individual responsibility such that the client decides on what the problem is;

3) stress internal attribution, i.e., that the problem is not beyond the client's control;

4) identify "cognitive dissonance", i.e., incongruence between client's goals/values and current drug use behaviour.

Motivational Guidelines (Miller, 1983) which can help mobilize clients to seek change are:

1) increase self-esteem through identifying strengths and successes;

2) increase self-efficacy by designing successes through assignment of achievable tasks;

3) increase dissonance between client's goals and drug use behaviour by pointing out discrepancies between them in the past, present and future;

4) direct dissonance reduction by negotiating plans for changing drug use, rather than changing goals and values.

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[26] Miller (1983)

Motivational Strategies (Zweben, 1984) which can be used to increase client's initiatives for change are:

TRAINER'S NOTES

1) reflective communication skills (active listening) to help engage the client, establish positive regard and build the helping relationship. These include: attending, paraphrasing, reflection of feeling and summarizing. (see Counselling Communication Skills – Unit I);

2) directive communication skills (responding) to provide a new awareness or alternative perspectives through probing, constructive confrontation, alternative interpretations (see Counselling Communication Skills – Unit I);

3) eliciting self-motivational statements for change, e.g., asking "What problems would you like to solve?", or "What would you like to change?"

4) presentation of alternatives, i.e., other ways to feel better or achieve the effects of drug use;

5) delayed compliance, e.g., suggesting that the client might not want to change or decide to change right away. This invites client's initiative on important decisions/actions.

6) role induction for treatment, i.e., explaining explicitly what entering into treatment would entail;

7) immunization against discouragement by indicating that there will be setbacks and difficulties, such as reactions from others and withdrawal symptoms;

8) reinforcement sampling of alternative behaviours can be negotiated as part of generating a more positive perspective toward change, and balance the anticipated loss involved in giving up previous drug use, with new gains.

Motivational Negotiation Principles (Fisher and Ury, 1981) which facilitate mutual planning are:

1) separate the person from the problem, by checking your assumptions (problems can be generalized but people are unique). Be tough on the problems but soft on the person.

2) focus on mutual interests, not rigid positions, e.g., "Here is what we agree on: the children need to have a different.....".

3) invent "options for mutual gain" (win-win), e.g., "Your goal of...and your desire for...can both be achieved through...".

4) Use objective criteria for measuring success, e.g., "We will know you have achieved...when...is observed".

Note: The above should take approximately 30 to 40 minutes, assuming that participants have adequately mastered the materials in Unit I (Counselling Communication Skills).

Practice

During the final 20 to 30 minutes the group should be broken into triads, and using one of the cases described in APPENDIX C of Unit III (or your own case example) give the following instructions.

In order to begin practising the application of these negotiation principles and strategies, your triad will be divided into the following three roles:

- Counsellor

- Client

- Observer/consultant

- The Counsellor will practise applying what has been discussed.

- The Client will act out the case example.

- The Observer/consultant will use the **NEGOTIA-TION CHECKLIST** (Figure 13, pages IV-62 to IV-63 in the Participant's Manual) as a reference while observing the interaction.

Approximately every two to three minutes the interaction will be stopped so that feedback can be exchanged:

- what the client experienced;

- what the counsellor experienced;

- what the consultant observed.

(See Unit I for guidelines for giving feedback)

Ideally, all participants will get a chance to experience all three roles.

The trainer may wish to vary the above sequence according to group needs and prior training.

Participants should be asked to note on their **NEGOTIA-TION CHECKLIST** (Figure 13, in Participant's Manual) which skills/areas they are strong in and which ones need more practice.

(See Figure 13, pages IV-62 to IV-63 in Participant's Manual)

ACTIVITY C

DECISION MODEL

Time required	40 minutes
Format	large group – lecture – discussion

Supportive — flipchart/blackboard
materials — overhead projector (optional)
— felt pens/chalk

Learning Participants should be able to explain the Decision
objective Making System for assessment and treatment inter-
vention and state why it is important.

Instructions For Training Activity C

Key Points:

1) Treatment planning leads to thoughtful, individualized treatment, based on assessment information.

2) Through consultation with others, it offers input from a variety of perspectives.

3) Treatment planning helps maximize the *appropriate* (best fit) use of service resources.

4) The treatment plan review process allows treatment to reflect changes in client behaviour and stage of dependence.

5) It is important to be aware of, and have access to, health professionals who are available for consultation.

6) The interviewer must negotiate the treatment plan with the client as well as with colleagues/consultants.

7) The negotiation process proceeds through several levels or stages reflected in the following questions:

   — Is there a *problem*?   (if yes)
   — Is *change* desired?   (if yes)
   — Can we *plan now*?   (if yes)
   — Can we *maintain* it?   (if yes)
   — success.

8) A no or uncertain answer to any of these questions indicates the need to negotiate whether and how to proceed. Without a yes at each stage from the client, the counsellor is proceeding without agreement, and *ALONE.*

9) Whether a successful plan can be developed or not, the client should be enabled to take responsibility for deciding what he wants to do. Present the decision making system using an overhead projection of the diagram on the following page (or by drawing it on the board).

A DECISION MAKING SYSTEM*

Assessment/Referral/ Treatment	Negotiation/ Case Management

Problem
?
— No → Negotiate — No →

Yes

Change
?
— No → Negotiate — No →

Yes

Yes

Implement
?
— No → Negotiate — No →

Yes

Yes

Success
?

No   Yes →

Return to one
of above

Case management
and follow-up
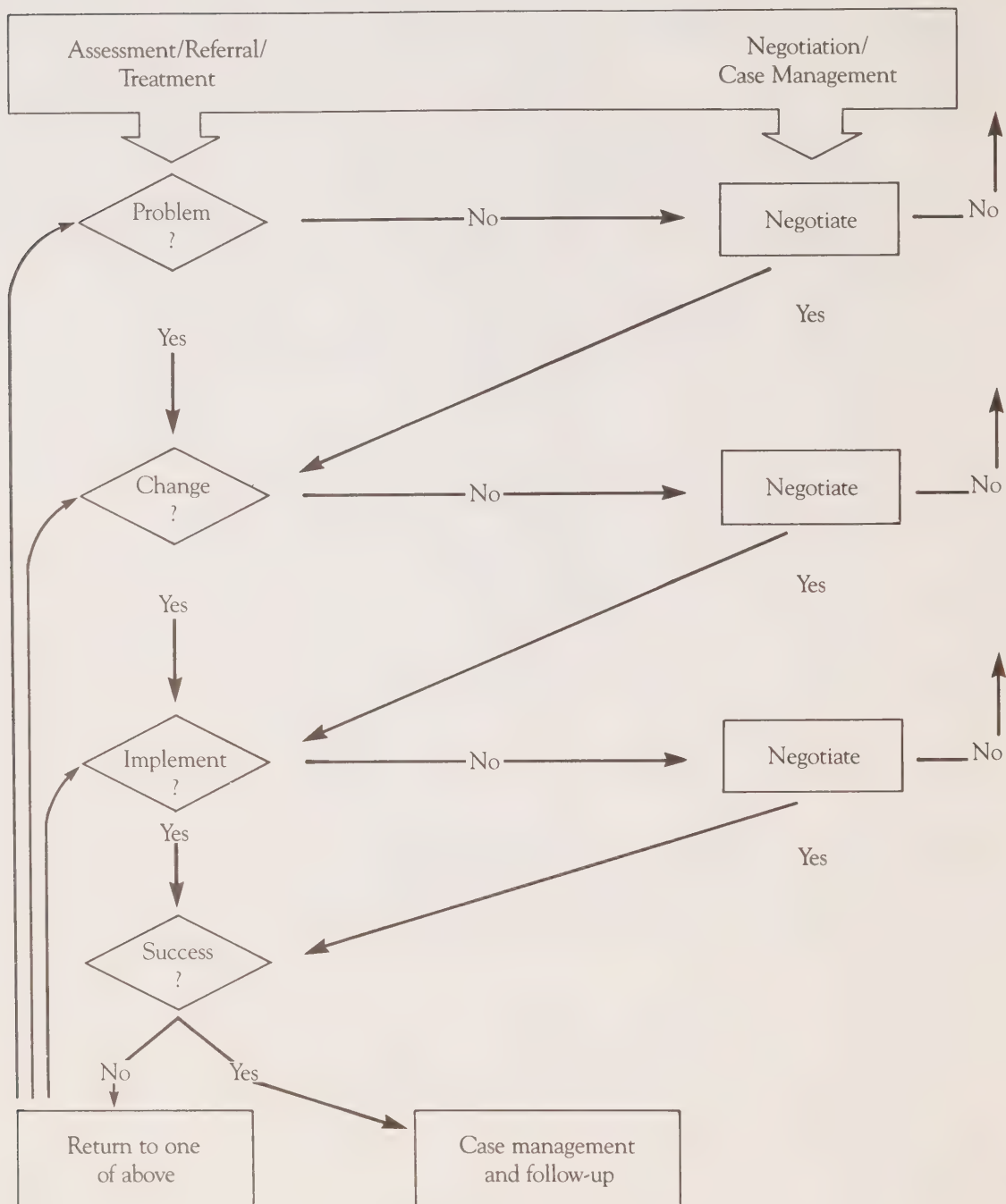
Stress that the importance of this model is that the counsellor can be clearly aware of whether the client is involved in actively working in the ASSESSMENT/REFERRAL/TREATMENT stream or the NEGOTIATION stream. This awareness helps avoid the confusion which can result when the counsellor thinks that the client is working in the former, while the client is still trying to make up his/her mind or is not ready to attempt change.

The counsellor should:

1) feel free to accept that the client is not ready for treatment, based on a functional analysis of the client's drug use and readiness to change.

2) be prepared to negotiate for a different perspective, (Using motivational interviewing strategies)

The above can be presented in approximately 20 minutes, leaving approximately 20 minutes for discussion of the above, related to case situations and previous materials. (See pages IV-7 to IV-30 and IV-62 to IV-63 in Participant's Manual)

ACTIVITY D

DIAGNOSTIC PERSPECTIVES

Time required	60 minutes
Format	large group lecture and discussion
Supportive materials	– flipchart/blackboard – chalk/felt pens
Learning objectives	By the end of this learning activity participants should be able to:

1) describe at least four different perspectives for explaining drug misuse;

2) describe four levels of drug misuse;

3) describe at least three vicious circles which help perpetuate drug misuse;

4) explain how antecedents and consequences contribute to drug misuse.

Instructions For Training Activity D

Introduction

Begin by stating that this session deals with ways of describing drug misuse in practical terms which help to diagnose the problem(s) for treatment planning.

Ask participants: "What makes drug misuse a problem?".

Write their responses on the board/flipchart, in point form, clarifying as necessary.

This should take about 10 minutes.

During the next 20 minutes present the following perspectives on drug dependence/misuse, referring whenever possible to the list of points generated by the participants.

During this 20-minute segment the emphasis should be placed on the relationship between how the client and counsellor explain drug dependence and what should be done to change it.

Key Points

1) Write the following on blackboard/flipcharts:

   – Moral-Legal Perspective

   – Disease or Public Health Perspective

   – Psychosocial Perspective

   – Sociocultural Perspective

2) Each of these perspectives has validity but each is based on different assumptions.

3) The moral-legal perspective assumes certain drug uses are: safe or dangerous; right or wrong; good or bad. The planning outcome is to construct moral sanctions, laws, regulations, and control mechanisms.

4) The disease or public health perspective considers the individual to be a "host" who is the victim of a drug agent in a particular context which places the person at risk. This perspective leads to planning aimed at curing the harmful consequences of drug use and/or preventing/reducing drug use.

5) The psychosocial perspective is concerned with the influence of family, peers and community factors. This view often recommends that problems not specifically related to drug use need to be alleviated as well as the drug use itself.

6) The sociocultural perspective recognizes that the society defines the meaning of drug use (and whether it is a problem), and determines social causes, such as poverty. The planning response tends to attempt to improve the quality of life and reduce social stresses.

7) An adequate analysis of a particular person's problem takes all of these perspectives into account from both:

   – the counsellor's perspective;

   – the client's perspective.

8) A plan which combines *both* the objective perspective of the counsellor *and*

9) the personal perspective/preference of the client has a better chance of being successful.

Allow some time for discussion, noting that most people perceive elements of two or more of the above within their personal perspective, which can be quite contradictory and confusing.

Stages of Dependence

Note that drug misuse involved more than one stage, as well as multiple perspectives. Describe them.

Key Points

1) Contact: first use for medical or nonmedical reasons.

2) Experimentation

  – Socially tolerated use: for social interaction and fun.

  – Integrated mode of use: regular pattern of use.

3) Excessive use

  – Incidental excessive: increased amounts.

  – Periodical excessive: increased dependence.

4) Addiction: damaging, autonomous, self perpetuating.

5) See figure 1, stages in process of drug abuse.

Display the diagram shown in Figure 1, either by overhead projector or drawing on the board/flipchart.

FIGURE 1

STAGES IN PROCESS OF DRUG ABUSE
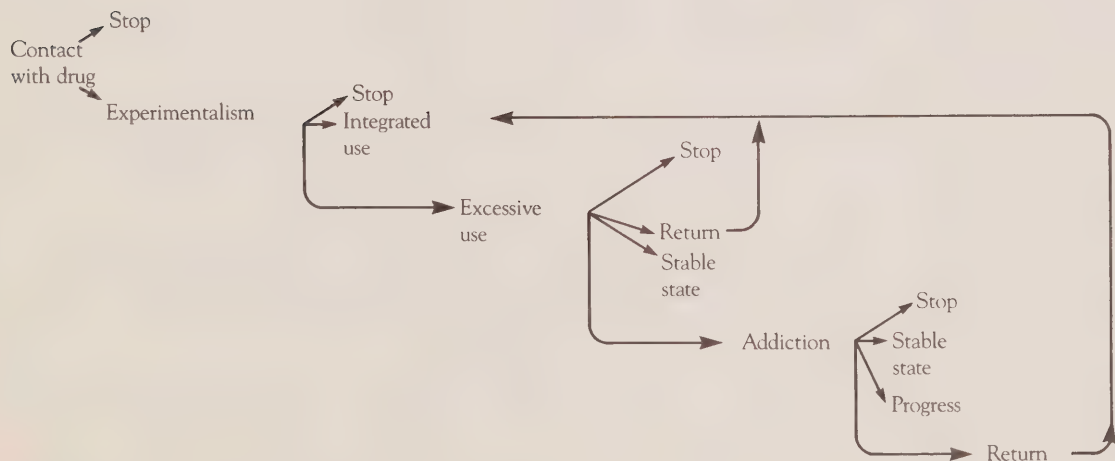
State the following:

If we looked at the stages in the process of drug use it would look like this:

(Point out each item as you say the item.)

1)   *Contact with the drug* (or)

   —   stop (or)

2)   *Experimentalism* (or)

   —   stop (or)

3)   *Integrated use* (or)

4)   *Excessive use* (or)

   —   stop (or)

   —   return to previous stage (or)

5)   *Stable state or excessive use* (or)

6)   *Addiction* (or)

   —   stop (or)

7)   *Stable state of addiction* (or)

8)   *Progress to higher degree of addiction* (or)

   —   Return to an earlier stage of use.

(this should take about 15 minutes)

Ask group members if they have questions; respond accordingly.

Write the following key points on flipchart/blackboard (underlined items)

GENERATING FACTORS

1)   *Pharmacological* effects of the drug.

2)   *Personal* factors of the user:

   —   Feelings of discomfort;

   —   Intense, unpleasant feelings;

   —   Inability to master intense, unpleasant feelings.

3)   *Social meaning* and value of a drug and drug-taking.

4)   *Environmental* influences on the user.

Note that *DRUG USE AS HUMAN BEHAVIOUR* (in addition to having multiple stages and perspectives) serves individual and social functions).

1)   Drug use varies from individual to individual, time to time, group to group, culture to culture, generation to generation.

2)   No simple relationships exist between causes and effects.

3)   Behaviour occurs in a social and cultural context.

4)   Beliefs and perceptions motivate behaviour.

5)   The behaviour of the drug user serves some physical, psychological, or social function.

Ask group members if they have any questions about the material presented thus far. If so, respond accordingly.

Display Figures 2 to 5 on the flipchart paper or prepared overheads.

The above points can be illustrated through describing a series of generating factors, as noted already on the board/flipchart.

Note that the pharmacological vicious circle is well established in clinical research, and although the others don't have this kind of empirical evidence, they fit well with some case experience and some conventional perspectives discussed earlier. The main point is that there are *multiple* causes/influences (See pages XX to XX in Participant's Manual).

This should take about 30 minutes, including some discussion.

Analysis of antecedents and consequences of drug use (approximately 30 minutes)

Begin by noting that treatment planning depends heavily upon changing established behaviour patterns.

Key Points

1)   Learning theory is helpful in functionally analysing drug dependence behaviour.

2)   Key questions:

   –   What happens before using a drug?

   –   What happens during drug use?

   –   What happens as a result of drug use?

3)   Answers to these questions make it possible to better understand the mechanisms which control addictive behaviours.

4)   Knowledge of desired consequences of drug use makes it possible to identify alternative, more healthy means of achieving those results.

5)   Sanchez-Craig (1984) has developed a concise therapist's manual which includes a questionnaire for analysis of alcohol misuse and its functions for an individual:

   –   To relieve negative feelings;

   –   to help in doing things;

   –   to medicate oneself;

   –   to reduce social pressures;

FIGURE 2
PHARMACOLOGICAL VICIOUS CIRCLE*

Use
of
Drug

Increase
of Need

Metabolic Changes
(i.e., Tolerance,
Withdrawal Syndrome)
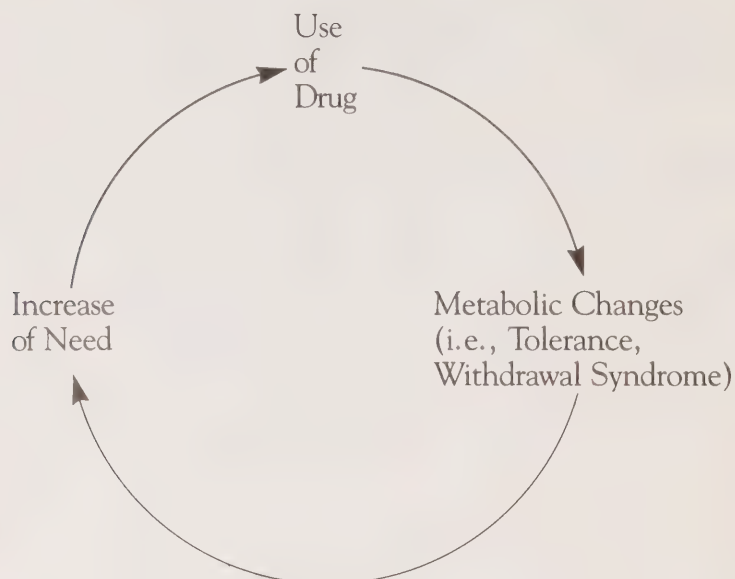
FIGURE 3
CEREBRO-EGO-WEAKENING
VICIOUS CIRCLE*

Use
of
Drug

Decrease of
Capacity of
Regulation and
Integration

Cerebral Damage

Decrease of
Resistance
Against Motivation
For Drug Use

Decrease of
Ego-strength

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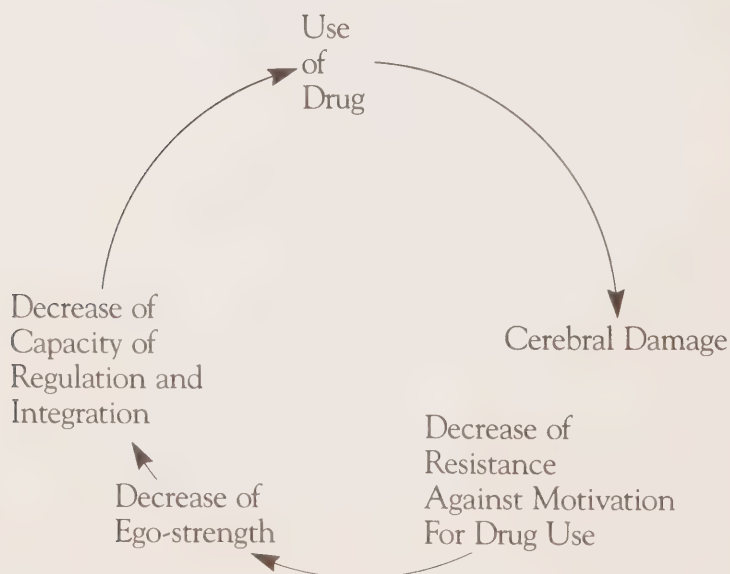
* National Drug Abuse Centre (1977).

FIGURE 4
PSYCHIC VICIOUS CIRCLE*

Use
of
Drug

Unpleasant Feelings
(i.e., guilt, shame,
discomfort)

Increase of
Need

Infantomimetic Effects
(Regression, Predominance
of Pleasure Principle,
Primary Process
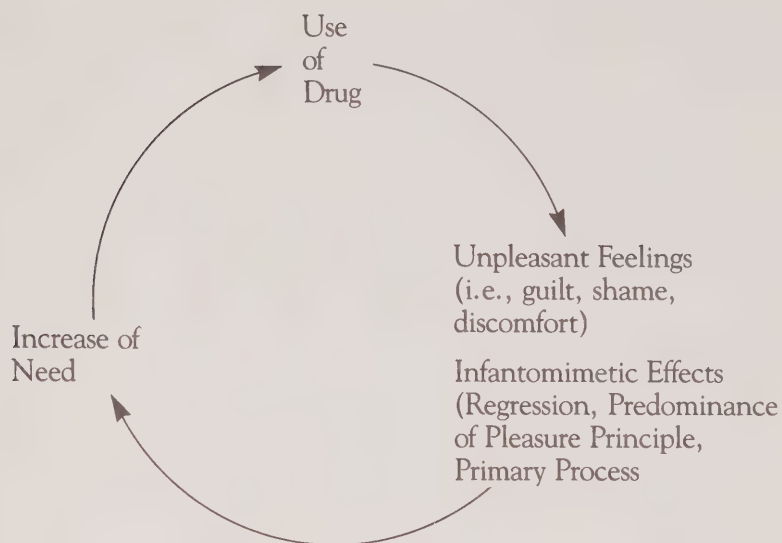
FIGURE 5
SOCIAL VICIOUS CIRCLE*

Social Context
of
Use of Drug

Increase of Need

(Increase of) Identification
with Social Role of
"Being an Addict"

Social Sequelae
(Tension, Conflicts,
Dropping Out)

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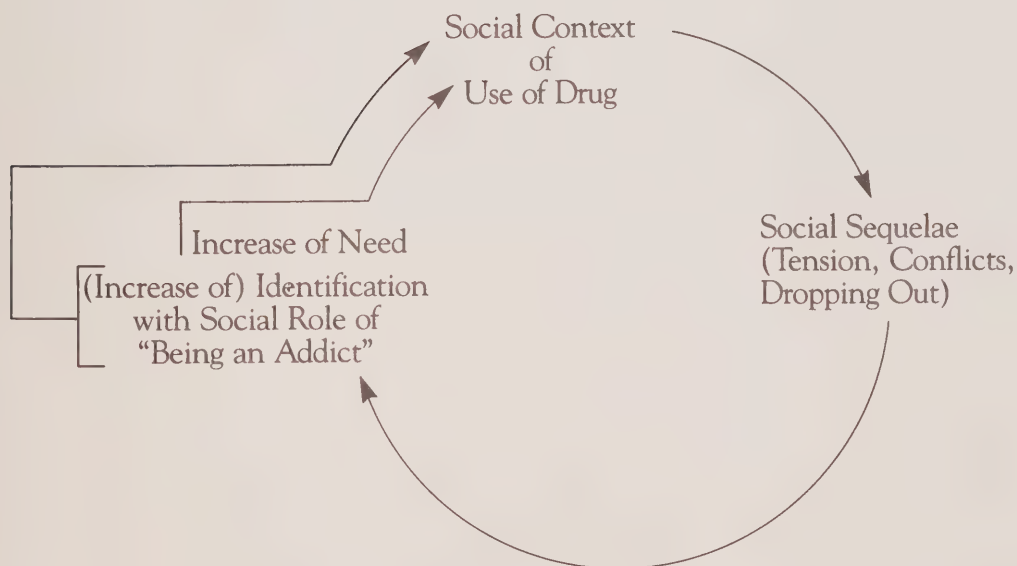
* National Drug Abuse Centre (1977)

—   to have pleasure;

—   for something to do;

—   other.

By describing precisely who, what feelings, what thoughts, what expectations are present before, during and after alcohol/other drug misuse one can specify risk situations and coping responses to these.

Summary

Draw Figure 6 (below) noting that if:

1)   benefits of drug use (A) (plus)

2)   detriment of no drug use (D) (are greater than)

3)   benefits of no drug use (C) (plus)

4)   detriments of drug use (B)

5)   i.e. if A + D > C + B (then)

6)   drug use will continue, in all probability.

Note that consequences are multi-dimensional, including:

1)   psychological;

2)   social;

3)   physical consequences.

FIGURE 6: CONSEQUENCES OF DRUG USE

	BENEFITS	DETRIMENTS
DRUG USE		
NO DRUG USE		

Treatment plan must be designed to alter this equation so that:

1)   benefits of drug use (A) plus

2)   detriments of no drug use (D) are less than

3)   benefits of no drug use (C) plus

4)   detriments of drug use (B)

5)   i.e., A + D < C + B.

Thus, treatment plans need to include how to:

INCREASE the benefits of *stopping* excessive drug use;

DECREASE the benefits of *continuing* drug misuse;

INCREASE the detriments of *continuing* drug misuse;

DECREASE the detriments of *stopping* excessive drug use;

(give examples of each of these briefly)

Some of the major consequences in the physical, social and psychological dimensions are described in Figure 7, according to progressive stages of use.

Unit III (Initial Interview Methods) describes some specific tools for organizing this information, e.g., the A.S.I.S.T.

Information obtained, using these (and other) diagnostic perspectives will be applied in module 3 (Matching), Activity C (Selection of Treatment).

Figure 7

INTEGRATED OUTPATIENT PROGRAM*

Intake and Screening

Abstinence Goal   Moderation Goal

Self-Help   Therapist-Directed   Therapist-Directed   Self-Help
Approach   Approaches   Approaches   Approach

Goal   Goal   Broad Spectrum Treatment   Goal   Goal
Attained   Attained   Attained   Attained

Relapse Prevention Program

Follow-Up
Additional Services as Needed
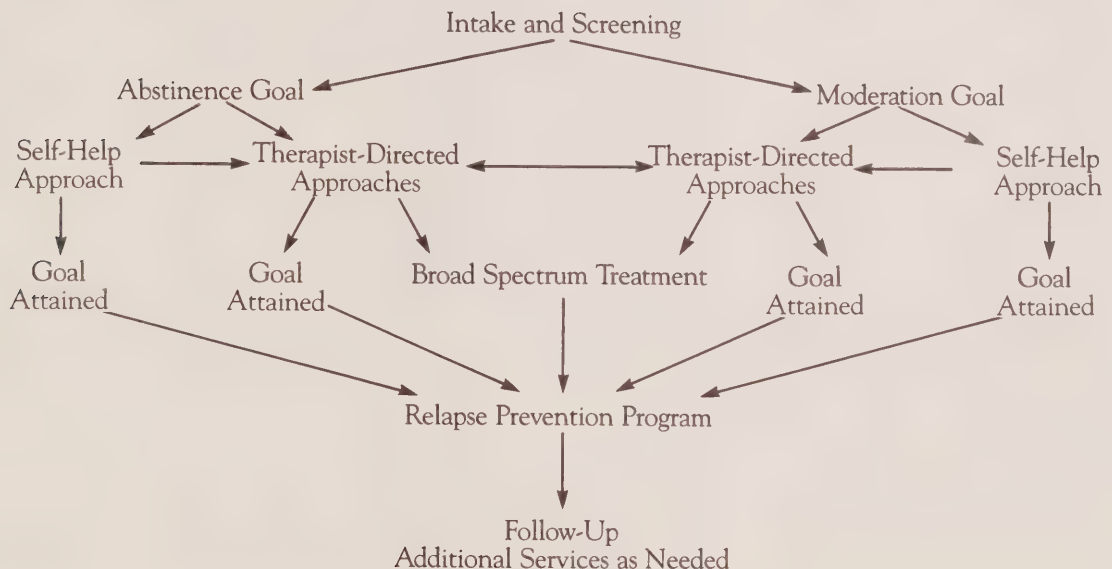
* Miller and Hester (1980) p. 110.

Antecedents, Behaviours, Consequences (Chaudron, 1984)

Introduction

We've begun talking about the stimuli, the cues, experienced before consumption and about the consequences of consumption.

What comes before can be referred to as the "Antecedents".

What comes after is referred to as "Consequences".

And so we have the A-B-C's of drug consumption:

The Antecedents
    Behaviours
    Consequences

Antecedents can be viewed as coming in two kinds (no fine line):

Historical = a fair time in the past, e.g. developmental history, innate biology

Immediate – happened recently, if not just before consumption

Consequences also can be categorized: Positive consequences are those that the user likes – the benefits of use – and negative consequences are those the user regrets. Positive consequences tend to promote use, while negative consequences discourage use.

Positive consequences = Reward = R:

Good things given $(R+)$

Bad things removed $(R-)$

Make consumption more likely.

Negative consequences = Punishment = P:

Bad things given $(P+)$

Good things removed $(P-)$

Make consumption less likely.

So, there we have the A-B-C's of drug use, for a start. The antecedent leads to the (drug-taking) behaviour, which is followed by the consequences.

Antecedents and consequences can be usefully categorized in three domains:

Physical (physiological)

Psychological (feelings, thoughts, behaviours)

Social (really environmental, but the human social environment is the dominant factor)

Ultimately it must be acknowledged these are not pure and discrete.

These elements can be combined into a 3 × 4 typology or grid which can be used to help understand drug-taking and drug avoidance.

FIGURE 8

INFLUENCES ON
DRUG CONSUMPTION

	Antecedents		Consequences	
	Historical	Immediate	Positive	Negative
Physical				
Psychological				
Social				

Some examples of how the grid can be completed are as follows:

Antecedents: Historical (vulnerability, risk, predisposition...)

Physical:

Genes

Drug use effects

General Health History

Psychological:

Self-concept

Happiness

Personality

Irrational beliefs

Social:

Culture

Family

Job

Friends, Social Circle

Antecedents: Immediate (triggers, stimuli, cues...)

Physical:

Withdrawal

Excitement

Pain

Psychological:

Frustration, anxiety

Elation

Boredom

Irrational beliefs

Social:

Party, company of peer

In a bar

Beer ad on TV

Consequences: Positive (reinforcing, increase probability...)

Physical:

Relief of pain, illness

Positive C.N.S. change (a high)

Relief of withdrawal

Psychological:

    Role success

    Tension relief

    Social facilitation

    Reverie, fantasy

Social:

    Approval

    Social success

    Escape critical scrutiny

Consequences: Negative (Punishing, decrease probability…)

Physical:

    Illness

    Injury

    Addiction

    Foetal alcohol syndrome

Psychological:

    Lowered self-esteem

    Decompensation

    Thought disorder

Social:

    Legal problems

    Social rejection, criticism

    Economic deterioration

Treatment and relapse prevention for drug problems involves:

1) Finding ways to reduce the positive consequences for drug-taking and increase the positive consequences for drug avoidance; also increase negative consequences for drug taking and reduce negative consequences for drug avoidance.

2) Developing and reinforcing new responses to old cues (triggers) for drug-taking; and finding ways to avoid those cues that continue to lead to drug taking.

3) Discovering new routes to obtain desired reinforcers.

4) Modifying the drug-taking behaviour itself. When drug-taking will occur, what quantity, what mode of administration, etc.

Module 2: MAJOR MODALITIES

OVERVIEW OF MODULE 2: MAJOR MODALITIES

Time required	60 minutes (1 hour)
Format	Large group – lecture – discussion
Supportive materials	– flipchart/blackboard – overhead projector (optional) – felt pens/chalk
Learning objective	To orient participants to major treatment approaches in relation to key issues affecting treatment selected and general guidelines for planning treatment.

ACTIVITY A
TREATMENT APPROACHES AND GOALS

Time required	60 minutes
Format	Large group – lecture – discussion
Supportive materials	– flipchart/blackboard – chalk/felt pens
Learning objectives	By the end of this learning activity participants should be able to:

1) list the three major goals of treatment (detoxification, abstinence, moderation);

2) discuss issues to consider in selecting a treatment approach;

3) describe general guidelines for designing treatment plans.

Instructions For Training Activity A

Introduction

Begin by stating that intervention concerning drug-related problems takes place at various stages (referring back to module 1). Early intervention may mean little or no treatment is required. Intervention at the later stages of dependence can require massive

treatment. Generally speaking, the earlier the intervention the less treatment is required.

The following discussion (about 30 minutes) will *not* attempt to provide in-depth information on the many approaches to treatment which exist. Most communities have only a very few to draw upon anyway. Rather, brief reference will be made to these approaches, and general variables which define them. Specific approaches will be discussed as these relate to *individualized* treatment planning.

Key Points

Interventions for drug misuse (depending on audience and location) select from following approaches:

PRETREATMENT APPROACHES

1) No treatment required
2) Drug information and education
3) Alternative programs
4) Community activities

TREATMENT APPROACHES

1) Detoxification
2) Treatment approaches oriented toward abstinence
   - "protective" medications
   - psychotropic medications
   - hallucinogenic drugs
   - aversion therapies
   - hypnosis
   - psychotherapy
   - Alcoholics Anonymous (AA)
   - group therapies
   - halfway houses
   - family therapy
3) Treatment approaches oriented toward moderation
   - behavioural self-control training
   - self-help
   - blood alcohol concentration (BAC)
   - training videotape feedback
   - cognitive therapies
   - operant approaches
   - multimodal treatment programs

- teaching alternatives to problem drinking
- relaxation training
- systematic desensitization
- social skills training

NOTE: Trainers should acknowledge that not all of the above are either available or relevant in all cases or locations. The outline is intended to indicate the wide range of modalities potentially available. Refer participants to their manual and Miller (1980) for more details.

The selection and use of any of these depends upon many general considerations, including:

ISSUES TO CONSIDER IN SELECTING A TREATMENT APPROACH

Treatment selected (in addition to being available) should be:

1) compatible with the client's perception of the problem;
2) consistent with the client's capabilities and strengths;
3) matched to the extent/degree/stage of the client's drug dependence;
4) outpatient if possible;
5) seen as the beginning of the solution, not the end;
6) included in a plan for relapse prevention;
7) offered in a way which allows the client to make a commitment him/herself to change;
8) negotiated, monitored, reviewed, revised, re-negotiated.

GENERAL GUIDELINES FOR DESIGNING TREATMENT PLANS

Treatment planning should take into account:

1) no treatment may be necessary, or no treatment may be possible;
2) the fact that most of the outcome of treatment appears to be determined by factors in the client's situation, rather than curative influences from the intervention;
3) individualized matching of client to the type of available resources is therefore extremely important in the sense that treatment selected should be tailored to support the client's strengths rather than the opposite;
4) no treatment may be better than too much or inappropriate treatment.

Modalities can be considered in relation to specific cases according to numerous variables.

The points on following pages can be used on flipcharts, blackboards, or transparencies to present and discuss the various modalities.

Variables used to define and organize treatment modalities[27]

Treatment is defined and organized according to the following dimensions:

- Theoretical model
- Treatment modality
- Intensity of treatment
- Population
- Substance
- Treatment goal
- Treatment research plan

The trainer can give examples of how some of the treatment approaches described earlier are defined and organized, e.g., AA can be defined according to substance (alcohol) and treatment goal (abstinence). Each of the above is discussed in the following sections.

Theoretical Model

- In-depth corrective psychotherapy
- Growth
- Interpersonal functioning
- Lifestyle
- Alternatives
- Behaviour directed

Treatment Modality

Examples for trainer to describe briefly:

- Individual therapy
- Marital therapy
- Family therapy
- Group therapy
- Milieu therapy

Intensity of Treatment

Examples for trainer to describe briefly:

- Drop-in counselling

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[27] Martin (1982)

- Outpatient therapy
- Day treatment
- Residential treatment

Population

Examples for trainer to describe briefly:

- Age variable
- Sex variable
- Employment variables
- Religious variables
- Ethnic/cultural/racial variables

Substance

Examples for trainer to describe briefly:

- Narcotics users
- Alcohol users
- Solvent users
- Polydrug users
- Benzodiazepine users

Treatment Goal

Examples for trainer to describe briefly:

- Abstinence vs non-problem drinking[28]
- Detoxification vs rehabilitation[28]
- Conversion experience[28]
- Improved interpersonal relationship[28]
- Crisis management vs rehabilitation[28]

Note: The trainer may wish to supplement the above using in-depth information about key treatment programs which are available locally. However, detailed information about *un*available treatment resources is often counter-productive.

TREATMENT GOALS WITH PATTERNS OF USE

(Examples using adolescent drug use as a case in point)

Treatment goals, like treatment approaches, need to be negotiated according to the stage of use/dependence. Examples are:

---

[28] Give specific examples.

(ideal)

1) *Initial use*

   Support termination of further experimentation at this time.

2) *Moderate use*

   Support avoidance of all forms of recreational or social drug and alcohol use at this time.

3) *Regular use*

   Intervene in the client's lifestyle and facilitate a total examination and reassessment. All drug use should be terminated within a short period of time.

4) *Heavy use*

   Engage any type of motivation that would facilitate total abstinence and establish a long-term treatment and follow-up plan.

(attainable)

1) *Initial use*

   Assist the adolescent (and his family) to understand the issues involved and to develop a personal policy towards future use.

2) *Moderate use*

   Demonstrate (from a fresh perspective) the consequences involved with social use and challenge the family to increase communication. Shift the emphasis awab01ay from drugs towards adolescent needs for personal growth.

3) *Regular use*

   Intervene in the immediate crisis and establish (if possible) a long-term individualized treatment plan.

4) *Heavy use*

   Assess the situation and develop an individualized treatment or referral plan.

The remaining 30 minutes, or so, should be devoted to discussing questions/aspects of the above lecture material. This can be done in the large group or in small groups for 15 minutes and then returning to the large group for additional questions.

(See pages IV-9 to IV-13 in Participant's Manual)

Module 3: MATCHING

Module 3: MATCHING

OVERVIEW OF MODULE 3: MATCHING

Time
required

90 minutes

Format

Large group and small groups
– lecture
– discussion

Supportive
materials

– Flipchart/blackboard
– felt pens/chalk

Learning
objective

To orient participants to the rationale and principles
for matching specific clients, with specific problems/
resources with individualized treatment options.

ACTIVITY A

MATCHING PRINCIPLES

Time
required

30 minutes

Format

Large group
– lecture
– discussion

Supportive
materials

– flipchart/blackboard materials
– chalk/felt pens

Learning
objectives

By the end of this training activity, participants
should be able to:

1) describe major treatment planning principles;

2) outline principles for matching;

3) discuss the major dimensions of matching (social,
psychological, physical).

Instructions For Training Activity A

Introduction

The trainer may begin by summarizing that, in a variety of ways,
the training so far has described knowledge, perspectives and skills
which help to stress what Pattison (1982, p.15) has stated:

> "The goal is to match a particular patient with an appropriate
> treatment facility in which he will be matched with

appropriate personnel, who in turn will match treatment to the patient's needs."

He (and we) acknowledge that this is a "large order". However, anything less is similar to providing the same size clothing to all patients. The same size clothes will fit some, but only a small minority.

Matching Principle

Meeks (1983) summarizes basic principles for matching as follows:

1) Alcohol – dependent patients constitute a hetero-geneous population, with a mix of pychological, social and physical problems;

2) careful assessment will identify the currently most serious problems;

3) no single treatment will be equally effective for all clients;

4) treatment settings should provide options and linkages with other agencies in the community;

5) the treatment system should provide mechanisms for matching clients with needed services;

6) whatever services are provided aftercare is essential.

Major Treatment Planning Principles

This treatment plan should be based upon *negotiation* within the following principles:

1) An individual appreciation of drug dependency (i.e., what is this particular person's situation?).

     – more than one perspective for understanding drug dependence should be considered.

2) the recognition that there are a series of stages of drug dependence which require different degrees of treatment.

3) a careful analysis of the generating factor contributing to a particular person's dependence pattern.

     – appreciation of the vicious circles which perpetu-ate the drug use and risks which contribute to relapse.

4) Knowledge of major modalities available for treatment, in general and in relation to:

     – actual client's capacities;

     – available treatment resources;

     – the best match between client's situation and available resources;

     – some means of ongoing facilitation and support of clients through the treatment system and follow-up care, i.e., continuing care/management.

A highly sophisticated application of the matching hypothesis awaits further development (Meeks, 1984). However, Pattison (1982) offers the following guidelines.

PRINCIPLES CONCERNING THE FACILITY

Each clinical facility should:

1) Examine and determine the type of subpopulation it serves;

2) determine what methods best serve this population;

3) stop using methods which are inappropriate or ineffective for this population;

4) pre-screen clientele, so that those admitted can be appropriately helped;

5) provide referral for those not appropriate;

6) provide several types of treatment, so that the client can select the type they prefer;

7) collaborate/negotiate with the client in selection of treatment methods/goals;

8) provide continuity of care;

9) provide access to ancillary services (e.g., food, clothing, shelter, legal aid, retraining);

10) provide outpatient follow-up services after inpatient treatment;

11) offer individualized treatment planning.

PRINCIPLES CONCERNING THE POPULATION

1) Simple psychological and social data provide better indicators for treatment selection than do complex test scores;

2) a past history of successful social adjustment is correlated positively with treatment success;

3) those who currently function well may be better candidates for aversive conditioning than for psychotherapy;

4) those who function well, but are experiencing emotional distress are more likely to accept psychotherapy and broad-spectrum behavioural approaches;

5) assistance with vocational placement and housing is important for those who have functioned well in the past, but who cannot now support themselves;

6) provision should be made for patients who are seriously impaired, and need long-term supportive care.

PRINCIPLES CONCERNING TREATMENT METHODS

1) Alcoholics Anonymous (AA) should not be used indiscriminately. It is best suited to patients who have a history of positive social relationships, desire group affiliations, and are guilt-prone (through their moral/ spiritual perspective).

2) Disulfiram (trade name: Antabuse) seems best suited to alcoholics who have a stable psychosocial background, want to abstain from alcohol use after many years of problem drinking, and have a good working relationship with treatment personnel who dispense the drug. Depression and/or impulsivity may be contraindications.

3) Broad-spectrum behavioural treatment and marital-family therapy seem to offer the best potential for extended treatment with individuals who are functioning well currently and/or in the past (despite excessive alcohol use). Reintegration with the family and community is promising for such persons.

4) Drug maintenance may be feasible for some patients, particularly those who are more: socially stable; psychologically dependent; positive in response to authority.

5) Severely deteriorated patients who have become disconnected from family, work and community ties are more likely to benefit from structured living programs which include re-education and vocational training.

6) Detoxification problems can often be handled on an outpatient basis.

PRINCIPLES CONCERNING TREATMENT GOALS

Evaluation and Assessment for treatment planning:

1) Begins with making personal contact with clients, i.e., engaging the client and obtaining his consent to participate in treatment;

2) should not precede engagement (above);

3) should include degree of impairment in major life areas (drugs, drinking, psychosocial, vocational, family, physical);

4) should estimate potential for change, considering degree of impairment, stage of life, and drinking/drug misuse history;

5) should lead to a mutual decision by the patient and the person counselling him, about what is desirable and possible in each area of impairment;

6) should include specific goals and specific means by which these goals are to be reached in each life area;

7) should include specific times to review treatment progress. This allows for feedback on and revision of the treatment plan.

This perspective is offered, not as a perfect approach, but as a means of increasing the "batting average" of treatment planning.

The above principles can serve as a useful framework for reviewing treatment programs, decisions, plans and goals.

NOTE: As an alternative to lecturing, the trainer may want to pre-circulate the above points and use the time in class to design or examine sample treatment plans for specific cases.

(See pages IV-35 to IV-43 in Participant's Manual)

ACTIVITY B

AVAILABLE RESOURCES

Time required	30 minutes
Format	Large group – lecture – discussion Small group discussion
Supportive materials	– flipchart/blackboard – chalk/felt pens – Available Resources list for local community
Learning objectives	Participants should be able to: 1) list the major treatment resources in their community; 2) describe the capabilities and limitations of those resources.

Instructions For Training Activity B

This module identifies and describes actual treatment resources available, in order to ensure that participants are familiar with the specific types and access procedures to treatment resources in their own community.

Introduction

The purpose of this module is to engage participants in a process through which they combine their knowledge and experience to identify the treatment resource network in their community and describe its actual strengths, limitations, and routes of access.

Begin by making the following points (first 30 minutes):

1) Most communities have relatively few of the possible treatment modality resources.

2) Competition often exists between them.

3) Coordination and collaboration are difficult to achieve.

4) Accurate and reliable information is a fundamental start.

5) The purpose of session is to help clarify what the actual treatment resource network[29] consists of and how it can be accessed.

Conduct a discussion of these points, listing key information.

Divide participants into small groups of 4 to 10 each, after large group discussion, for next 30 minutes.

NOTE: This exercise depends heavily on having a participant group with members who have inside information on elements of the treatment resource network.[30]

Instructions

1) Provide each small group with a list of three or more treatment resources in their community.

2) Direct participants in each group to spend five to ten minutes discussing and sharing tips on how to make more effective referrals to each of the resources.

3) Be certain that each group has members who can act as information sources on each of the resources on their list.

4) Ask groups to make notes on their flipcharts.

5) Reconvene participants into large groups after time is up.

6) Ask participants to outline what they had concluded about each resource.

7) Reconvene the large group and ask for reports from each group.

8) Summarize recommendations on flipchart/board.

9) Point out how helpful they have been and can continue to be if they continue to develop this network for resource consultation. (See pages IV-43 to IV-46 in Participant's Manual)

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[29] AVAILABLE RESOURCES:

A resource profile handout specifying the local resource network for the participants should be prepared in advance. This should list and briefly describe the treatment resources which they have available to them in their local area.

[30] If participants do not have this information, then knowledgeable facilitators will need to be provided to each group.

ACTIVITY C

SELECTION OF TREATMENT

Time required	30 minutes
Format	– Large group – and/or small group
Supportive materials	– **"SELECTION OF TREATMENT CHECK-LIST"** (Figure 11, page IV-49, Participant's Manual)
Learning objectives	Participants should be able to: Select and justify a treatment resource which matches a simulated client assessment profile.

Instructions for Training Activity C

Introduction

Note that, in order to integrate and apply the instructional content presented so far in this module, participants will now take part in a practice exercise.

1) Trainer uses a completed assessment report (with names deleted, to preserve confidentiality) and acts as (role plays) the client.

2) Participants, using the **SELECTION OF TREAT-MENT CHECKLIST**, ask the client as many questions as they feel are necessary to make a treatment service selection (first 15 minutes)

3) Trainer fills in information not adequately obtained by participants.

4) Participants, using the **AVAILABLE RESOURCES LIST** for their community, (revised during the previous module on **RESOURCES**) each select a treatment and indicate their choice to the trainer.

5) All selected services are recorded on the flipchart/board.

6) The appropriateness of each selection, (in light of the actual case and instructional material so far), is discussed, with the trainer giving specific feedback on each choice.

Module 4: CONTINUED CARE/MANAGEMENT
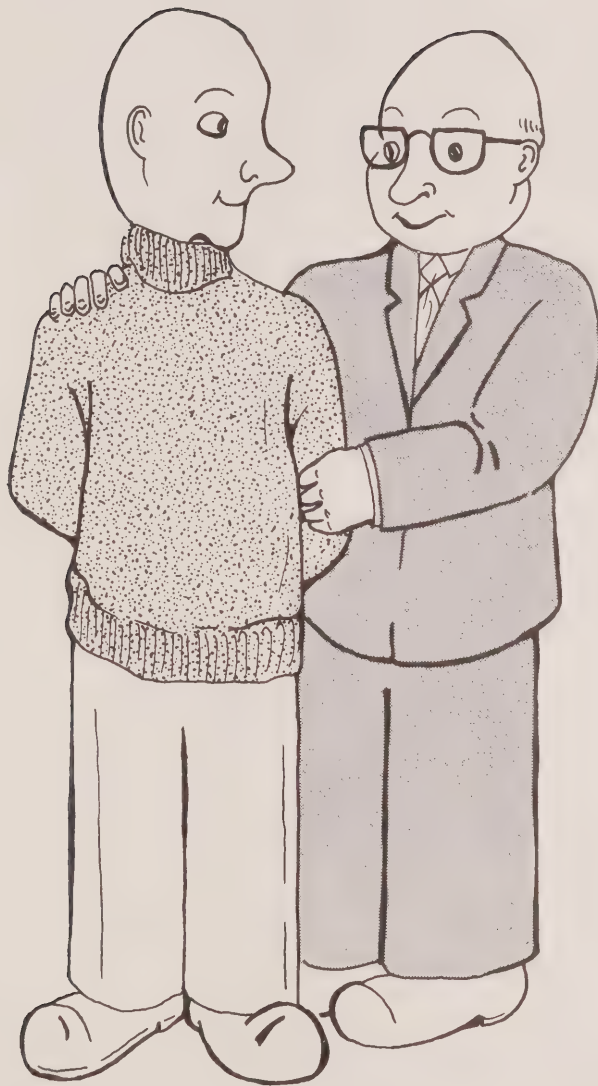
Module 4: CONTINUED CARE/MANAGEMENT

OVERVIEW OF MODULE 4:
CONTINUED CARE/MANAGEMENT

Time required	75 minutes
Format	– Large group (lecture) – Small group (exercise) – Large group discussion/conclusion
Supportive materials	Flipchart/blackboard felt pens/chalk
Learning objective	This module is designed to orient participants to the rationale for general functions of, and relapse prevention/response functions of, continuing care/case management.

ACTIVITY A

CASE MANAGEMENT

Time required	15 minutes
Format	Large group
Supportive materials	– flipchart/blackboard – chalk/felt pens
Learning objective	Participants should be able to: Explain the major roles, activities and purposes for case management.

Instructions For Training Activity A

Introduction

Note that in recent years the concept of case management has become increasingly important in health and other human services. It is an essential aspect of any treatment plan.

Kurtz (1984) and her colleagues have described case management activities within five areas (write on board/chart):

–	**ASSESSMENT**	–	**MONITORING**
–	**PLANNING**	–	**ADVOCACY**
–	**LINKING**		

These functions are particularly important in the complex area of substance misuse, in view of the frequent scarcity of specialized treatment services. That is, many agencies may be involved in one treatment plan. The case manager can act as a kind of specially trained guide to help ensure that clients actually implement the treatment plan once outside the centre which acts as the point of entry to treatment services.

– Briefly outline the following range of possible case management activities, giving examples from your experience.

– Note at the beginning that research has found these activities to be critical in fostering successful community adjustment by many clients. (Baker and Weiss, 1984).

ASSESSMENT

– telephone intakes

– office intakes

– emergency screening

– social histories/assessment reports

– family interviews

– information from other agencies

PLANNING

– service plans

– consultations for planning

– arrange/attend case conferences

LINKING

– arrange appointments

– meetings with other agencies

– visit clients

– plan discharge

MONITORING

– discuss progress with clients

– monitor through consulting with other agencies;

– read progress notes

– conduct follow-ups

– consult with families

- help obtain services needed

- negotiate disputes

- encourage resource development

Conduct a discussion regarding the above.

- Note that, in the case of the substance misuse client, many of these activities are associated with:

    1) RELAPSE PREVENTION

    2) RELAPSE RESPONSE

- Note that in the next training activity, small groups will be given the task of designing a relapse prevention and response plan for a simulated case.

(See pages IV-57 to IV-62 in Participant's Manual)

ACTIVITY B

RELAPSE

Time required	30 minutes
Format	– Small group exercise – Large group discussion
Supportive materials	– Flipchart/blackboard – chalk/felt pens – **Relapse Prevention and Response Plan Checklist** (Page IV-60 in Participant's Manual) – **Dependency Checklist** (filled out earlier in module 1 of this Unit)
Learning objective	Participants should be able to: design a relapse prevention and response plan for one of their own (minor) dependencies.

Instructions For Training Activity B

Introduction (first 15 minutes)

Begin by noting that some traditional views and myths have held that users of alcohol and/or other drugs are divided into two kinds of groups e.g.:

- alcoholic and *non*-alcoholic;

- drunk and sober;

- addict and *non*-addict;

-     "on the wagon" and "off the wagon";
-     (the list can be added to).

The point to be made here is that these sorts of polar or dichotomous views tend to ignore individual differences. They also suggest that some kind of mysterious force leads the alcohol misuser inevitably from one drink to total loss of control (one is too many, 100 is not enough).

The simple fact is that "one drink does not a relapse make".

However, clients need to be prepared and supported in an individualized plan for:

1) preventing relapse;

2) responding constructively when it happens.

Marlatt (1979), Cumming *et al* (1980) have developed some practical guidelines for preventing relapse.

These involve:

1) identifying risk situations;

2) developing coping responses.

Prevention through risk reduction

Within the functional analysis completed in the assessment/ treatment planning process, cognitive and behavioural antecedents to abuse should have been identified. This information can be used during treatment and discharge planning to specify: under what circumstances (e.g., with whom, when, where, and in what mood) relapse generally occurs.

Clients can be taught to recognize specific warning signs and avoid entering these situations (e.g., the combination of being angry with a spouse and going to a pub). Frequently a particular social group or person represents a high-risk situation (e.g. "drinking buddies").

Coping Responses

Avoidance of high risk situations is not, by itself, adequate. Clients need to learn and develop "how to" ways of doing this, because part of the high-risk situation is the client's proven inadequacy in dealing with these situations (emotionally, intellectually and behaviourally) in the past.

For example, the client can be supported and helped to:

1) Learn alternative ways of dealing with stress (give examples);

2) learn assertiveness skills (e.g., how to say no) for preventing stress (give examples);

3) learn desensitization responses to stressful situations (explain);

4) practise constructive relapse responses to prepare for the possibility of a slip (so that one episode of use does not become a full-blown relapse);

5) alter his/her view of relapse, so that it is seen as a problem to be dealt with, rather than a hopeless situation;

6) develop positive dependencies which are achievable and incompatible with drug dependence/misuse (e.g., exercise programs, learning programs, new hobbies);

7) prepare family and friends to help prevent and respond constructively to relapse.

Because some degree of relapse is predictable for most clients treated for addictive behaviours, relapse prevention/response may be the single most important aspect of counselling communications, assessment interviewing, treatment planning, follow-up and case management.

Addictive behaviours are a result of some personal *predisposition*, some form of *precipitating* events which initiate use, and influences which *perpetuate* the drug misuse pattern.

Recovery from drug dependence and relapse prevention/ response planning must address all of these influences in order to be successful. Continuing care and case management are thus essential to that success, because it can assist in the long-term re-learning process involved.

Warm-Up Exercise (30 minutes)

- After answering questions regarding the above material, divide the participants into small groups of four to ten each.

- Instruct them to review their completed dependency checklist. During the next few minutes they are to (working in pairs) select one of their dependencies, and (using the Relapse Prevention and Response Plan Checklist and the principles just presented), develop a relapse prevention/ response plan of their own (assuming for the moment that they wanted to change that dependency).

- Stress that this plan need *not* be acted upon in their daily lives. It is only an exercise.

- Reconvene the large group and lead a discussion on what they learned in the process. Note that in the next exercise they will continue to practise the application of these principles.

(See pages IV-57 to IV-63 in Participant's Manual)

RELAPSE PREVENTION PLAN

Time required	30 minutes
Format	– Large group – and/or small group
Supportive materials	– **"RELAPSE PREVENTION AND RESPONSE PLAN CHECKLIST"** (Figure 12, page IV-60 Participant's Manual)
Learning objective	Participants should design a Relapse objective Prevention Plan based upon a sample case situation.

Instructions For Training Activity C

Introduction (10 minutes)

Begin by outlining the following points from Marlatt's (1979) model;

1) The abstinent person feels in control until he encounters a situation which challenges his perception of control;

2) usually the person has not developed (or considered) an effective method of coping with these high risk situations;

3) he has positive expectancies about the effects of using the substance;

4) he consumes the substance;

5) he assumes he can't stop consuming the substance (abstinence violation effect);

6) the probability of continued use increases markedly.

Prevention and Response:

Note that, in order to prevent (or reduce the chance of) relapse and prepare for possible relapse, a specific plan is required. This plan should include (review the following presented earlier):

1) Learning warning signs;

2) developing coping responses;

3) improving knowledge and learning new achievable skills required to develop positive dependencies/alternative activities;

4) monitoring progress;

5) practising constructive relapse responses;

6) changing perceptions which lead to a hopeless or helpless view of relapse.

Note that this is essential in order to counteract/prevent the abstinence violation effect.

7) preparing family/friends for how to respond constructively;

8) identifying people and resources to turn to in the event of relapse.

(first 10 minutes)

Practice Exercise (20 minutes)

For the remaining time, again use the completed Assessment Report used in module 3 (Matching) Activity C (Selection of Treatment), as follows:

1) Trainer role plays the client described in the assessment (first 10 minutes);

2) participants use the **"RELAPSE PREVENTION AND RESPONSE PLAN CHECKLIST"** (Figure 12, page IV-60 in Participant's Manual), and ask the "client" as many questions as necessary to develop a relapse plan;

3) answers are outlined in point form on the flipchart/board;

4) for the last 10 minutes the (collective) participant group designs a relapse plan, working with the trainer. This is written on the flipchart/board, and discussed;

5) the trainer critiques the plan, pointing out/giving feedback on its strengths and weaknesses. (refer to pages IV-57 to IV-63 in Participant's Manual).

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ADDICTION COUNSELLING TRAINING MANUAL

PARTICIPANT'S MANUAL

COMPLETE TABLE OF CONTENTS

ACKNOWLEDGEMENTS

PREFACE

This resource is the result of a project undertaken by the National Planning Committee (NPC), a working group of the Subcommittee on Alcohol and Other Drug Problems in Canada, to enhance knowledge and skills in the addictions counselling field. By 1980, this group had already spearheaded successful projects for training trainers and teaching basic knowledge in the addictions area. Working again through the committee and its national training system framework, this group identified a substantial priority for "counselling skills training" across Canada.

Although there were numerous training programs, courses, and efforts existing in the various jurisdictions, there was an identified need to bring these resources together into a "state-of-the-art" curriculum which would serve as a baseline for training counsellors.

A Canada-wide needs assessment indicated that treatment related programs were often too long, too abstract, too advanced, not practical enough, not written down and too inflexible for front line trainers.

The Addiction Counselling Training (ACT) package is a modularized set of training materials drawn from contemporary sources in the field. It addresses the need for basic, brief training of workers new to counselling the drug dependent person.

The package consists of manuals for both trainers and participants. It is designed to be part of a larger training strategy, and can be easily modified or supplemented in order to meet more specific trainee requirements. Primarily, it attempts to address basic (i.e., fundamentally important) skills and knowledge which have broad relevance to many work settings.

The goal of this package is to enable addiction counsellors in the National Training System:

1) to receive a relevant, consistent, and comprehensive form of introductory-level or review training;

2) to be motivated to continue their training;

3) to achieve a clear, practical, basic foundation of knowledge, skills, attitudes, and continued learning tools.

The package is based upon a learning model which assumes that specialized knowledge and skills are best learned in a sequence in which more specialized, complex learning builds upon basic skills and knowledge.

The purpose of this material is *not* to suffice as counsellor training in and of itself, but rather to serve as a resource for training addiction workers who require some or all of this specialized knowledge and skill instruction. The package assumes no prior training in addiction counselling. It is modularized in such a way that it can be used totally or in part depending upon:

1) participants' backgrounds (prior training);

2) locally specific knowledge/skill requirements.

The beginning worker with less than one year of experience and no formal training is the primary target; however, the materials are also of potential use as refresher training for more experienced workers.

The package is made up of selected existing resource materials. Some are quoted, others are slightly edited, and others are summarized. Materials produced by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) and the National Institute on Drug Abuse (NIDA)

have been updated and directly quoted without line by line referencing in some specific passages. This liberty was taken within the spirit of their policy on the materials being public domain. All other citations are made as specifically as possible.

The ACT package is intended to be part of a more extensive training program. No pretense is made, nor is it assumed, that the completion of this program is sufficient for training counsellors.

The knowledge and skills training objectives of this package focus on pre-treatment counselling activities: that is, up to, and including, treatment planning activities, but not including specialized treatment.

There is an acknowledged emphasis on the more popularly used drugs (alcohol, barbiturates, antianxiety tranquillizers, and cannabis). As well, knowledge concerning risks and hazards of using specific drugs is uneven. Consequently, this unevenness is reflected in the content.

Extensive attempts have been made to ensure that the material included is up-to-date and accurate. With changing knowledge, this objective is elusive. However, the strategy being recommended is that users of the package continuously monitor and update the technical content. Thus, this manual and those that follow it should always be considered working documents. This leads to one final comment. There is no substitute for a creative and experienced trainer. This said, however, training aids can assist in making program planning and delivery more efficient. The materials in this manual have been found useful in coping with the demands of variable target group needs and continuous staff turnover/retraining requirements.

INTRODUCTION

TABLE OF CONTENTS

Module 1: RATIONALE

- Rationale
- Objectives
- Content

INTRODUCTION TO THE ACT PACKAGE

Module 1 : RATIONALE

Why the ACT package?

In reviewing counselling training materials available, two extremes were observed:

1. Long, time-consuming packages which could not be used due to time constraints (not enough time for training);

2. Training materials which were very minimally documented (often existing in resource persons' heads).

The net result was that counsellor personnel were often not well prepared. This package presents fundamentals of inter-personal skills, drug information, interviewing, and individualized intervention planning to help trainers overcome time constraints.

What is the ACT package?

This package consists of two sets of materials:

1. A Trainer's Manual, which consists of:

   – trainer instructions,

   – training goal/objectives,

   – training materials (notes, exercises, activities).

2. A Participant's Manual, which consists of:

   – participant's readings and references

The materials are organized in a modularized fashion, so that they can be used flexibly, according to particular participant group training needs. The four Units present interlocking topic areas, and each Unit is divided into modules or sub-topic areas.

These materials can be drawn upon to meet varying competency or learning needs, within whatever time is available. Thus, one or more modules from one or more Units can be organized and presented in one large "block" of time, or spaced out over several days/weeks (e.g., one hour per day or one day per week). These may be supplemented and/or altered. The Participant's Manual contains a number of checklists in addition to readings. These may be useful as job aids as well as learning aids.

Module 2: OBJECTIVES

REVIEW: Learning Experiences
Outcomes Intended
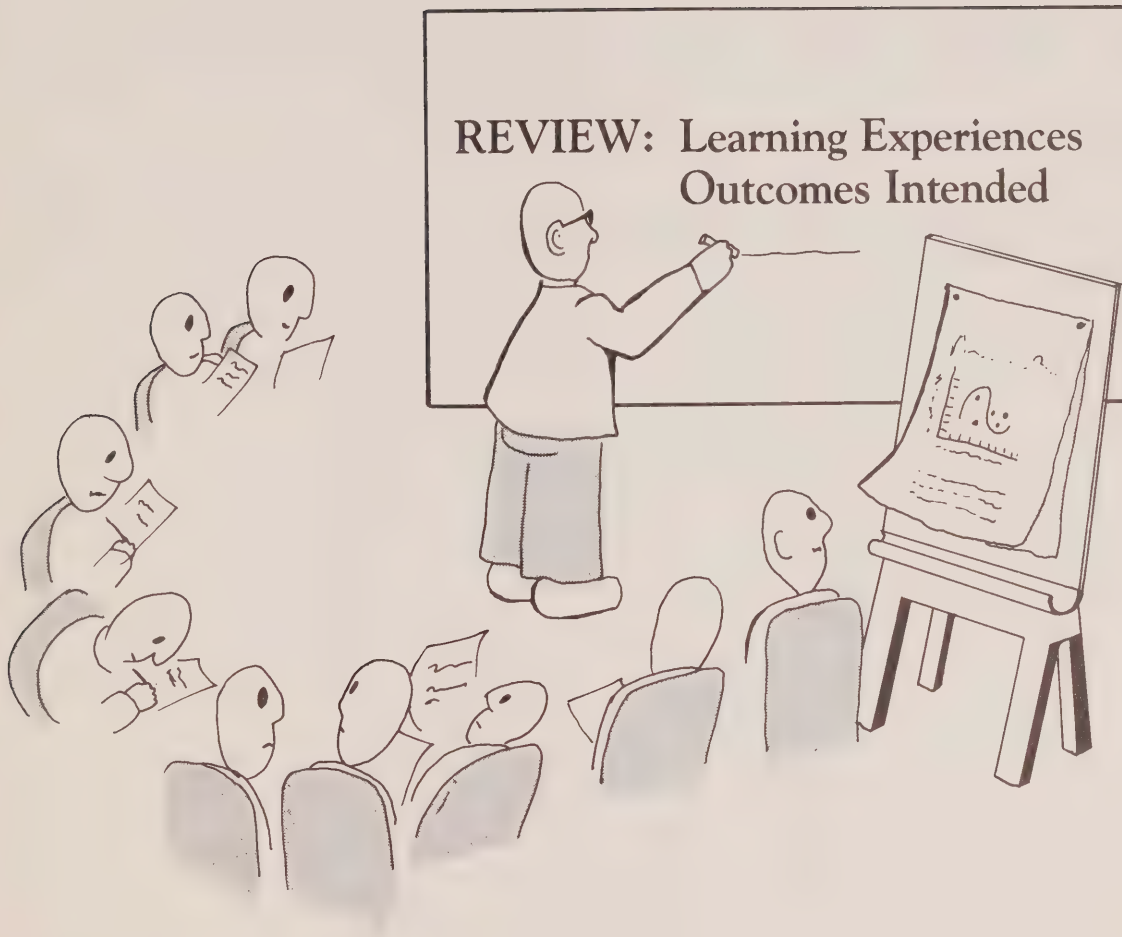
Module 2: OBJECTIVES

Scope and limits of the ACT package

It is possible to view this package as either too much material or not enough material on the subjects covered. The judgment depends almost entirely on the baseline knowledge/skills of the participant group and the amount of time available for delivering the training. The need and priority for training should determine whether and how these materials are used.

The package does not purport or attempt to go beyond basic (i.e, fundamentally important) knowledge and skills for assessment, treatment planning, and case management functions of counselling. It assumes that continued training will be necessary.

Goals and objectives

To the extent possible, each session relates to specific instructional goals and objectives. These are stated at the beginning of each Unit and module. The following areas are covered:

- The first Unit (Counselling Communication Skills) focuses on practising interpersonal skills which are needed to establish and maintain a positive relationship as well as to deliver counselling interventions effectively.

- The second Unit (Practical Drug Concepts) is directed at enabling counsellors to know what and how drugs affect users, in terms of major hazards and indicators to estimate risks.

- The third Unit (Initial Interview Methods) provides guidelines and practice for assessment interviewing. It combines counselling skills and practical drug concepts around methods of exploring, analysing, and organizing client information for treatment planning.

- The fourth Unit (Treatment Planning Strategies) describes principles, approaches, and tools for understanding individual patterns of substance abuse for purposes of treatment planning and case management. Specialized treatment approaches are referred to, but not covered.

- Module four of this (Introduction) Unit on training needs provides an opportunity and structure for specifying what present and further training is required for those who participate in this program.

Figure 1 outlines the Units and modules covered.

Module 3: CONTENT
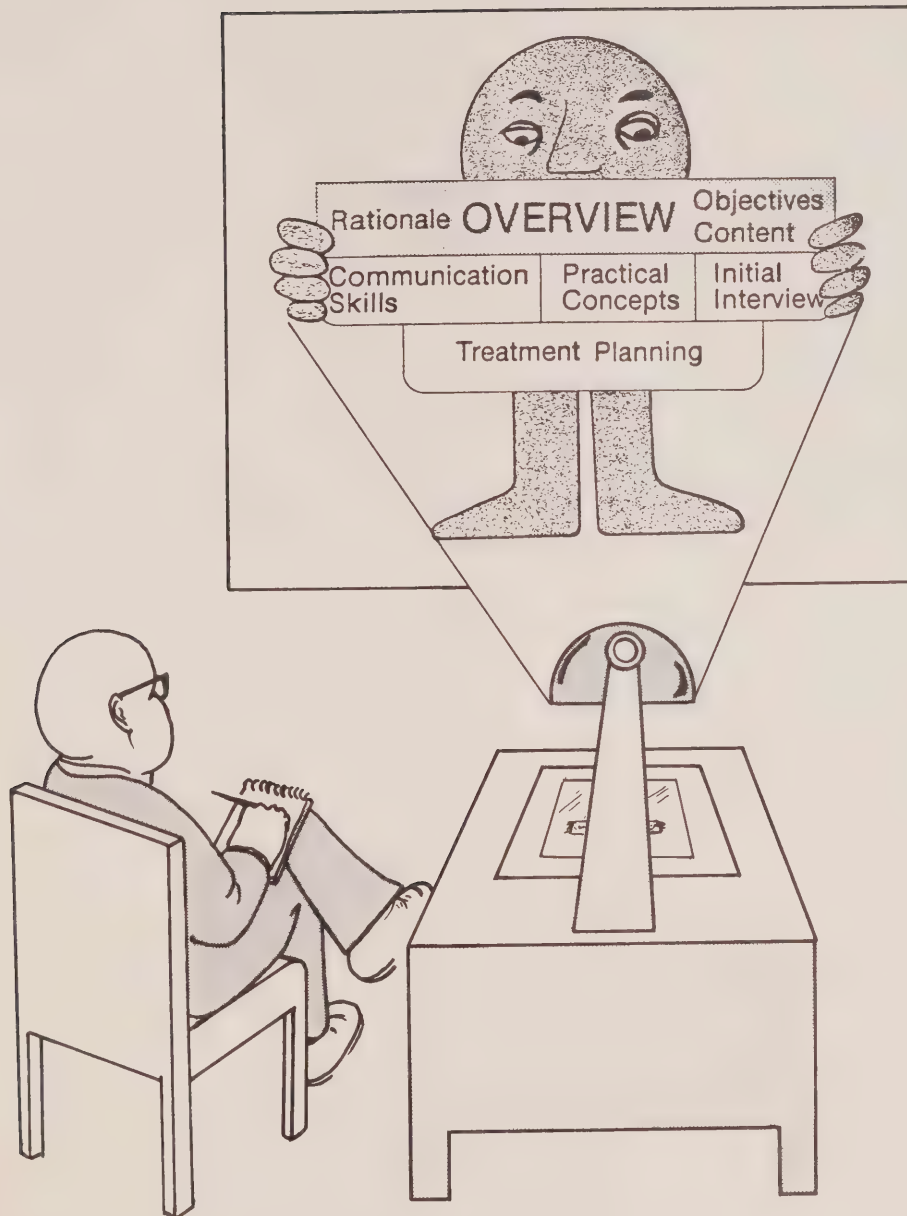
Module 3: CONTENT

Addiction Counselling Training Package Content

Figure 1

	UNITS			
	I	II	III	IV
MODULES	COUNSELLING COMMUNICATION SKILLS	PRACTICAL DRUG CONCEPTS	INITIAL INTERVIEW METHODS	TREATMENT PLANNING STRATEGIES
1	ORIENTATION	DRUGS	ASSESSMENT	FUNCTIONAL ANALYSIS
2	REFLECTIVE SKILLS	HAZARDS	THE INTERVIEW	MAJOR MODALITIES
3	DIRECTIVE SKILLS	RISK INDICATORS	SIMULATION	MATCHING
4	OBSERVATIONS AND CONCLUSIONS	CASE APPLICATIONS	ASSESSMENT DOCUMENTATION	CONTINUED CARE/ MANAGEMENT

Module 4: TRAINING NEEDS PROFILE

Module 4: TRAINING NEEDS PROFILE

PROFILING AND TARGETING[*]

Training and Development Needs
A Summary and Review

Questions

1) Can the problem be solved by training?

2) What kinds of training and development activities are most needed?

Priority and perceived need for training activities are influenced by:

- turnover of staff;

- new products/programs;

- size of training budget;

- time-frames for design, production, and delivery of training programs;

- availability of "slick" training materials;

- complaints, or other "squeaky wheels".

While a focus on short-term or immediate needs training occurs in most programs, a long-term perspective must also be maintained to guide the organization's training investments for the future (programs, equipment, materials, facilities, and personnel).

Often reactive approaches to meeting training needs divert resources away from more vital priorities related to the organization's goals. Reactive approaches are thus inadequate for the following reasons:

- they are directed by short-term problems, and ignore long-term priorities;

- they are often based on limited information;

- they do not reflect an investment policy in training (therefore, they vary tremendously according to fiscal constraints);

- to ensure acceptance, they are often very general, so as to apply in a wide variety of situations, or they are "trendy";

- usually they do not receive enthusiastic endorsement, nor do they achieve long-lasting results.

To avoid reactive approaches, problems which can be solved through training must be distinguished from those for which training is inappropriate (e.g., policy determination, personnel problems, working conditions).

Content, structure, and strategies of a training program must be determined by a process of identifying, prioritizing, and making commitments to legitimate training needs (needs assessment).

Needs Assessment (the difference between what should be and what is now).

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[*] Bernhard & DiPaolo, (1982).

Approaches vary with situation (e.g. time, resources available). Techniques include:

- standardized surveys;
- structured and unstructured interviews, with selected personnel, at various levels;
- structured and unstructured meetings with key personnel (often upper-level management), e.g. nominal group techniques (see Appendix A);
- review of documents and work samples;
- on-site observations;
- review of research and thinking which is published in the particular field;
- combination of the above.

Each of these has strengths and weaknesses. The best approach, obviously, is the one which will most quickly and accurately target/profile long-term, high-priority training and development needs.

Systematic Technique for Assessing Resources and Training/Development (START) is a composite approach. Its activities are:

- *identify* training *needs* from multiple resources (noted above);
- *separate* training *problems* from non-training problems;
- sort the training/resources information in an *"action framework"* (e.g. DACUM format, see Appendix B);
- *rank* the *topics* to establish long-term programs;
- *build consensus* on *how/when* training needs are to be met.

START phases:

- *review* alternative data collection techniques;
- *consult* management and confirm selected strategies;
- *conduct* cycles of data collection and analysis;
- *sort/separate* training and non-training problems;
- *conduct structured meetings* to confirm and gain commitment on long-term training programs.
- review data;
- place topics in a long-term program (five years);
- establish commitment at all levels, consistent with organization goals.

Summary

This kind of approach:

- increases your chances for gaining a clearer picture of needs for training, in line with organization goals;
- provides more comprehensive needs assessment results, covering more topics;
- uses more precise data, resulting in less arbitrary training decisions and a more professional image.

A. History

DACUM (*Developing A Curriculum*) is an approach to the development of curricula combined with an evaluation process for occupational training programs. It was created initially in a joint effort by the Experimental Projects Branch, Canada Department of Manpower and Immigration, and General Learning Corporation of New York, which provided technical direction to the Women's Job Corps program at Clinton, Iowa. Early efforts at Clinton were intended to produce a curriculum guide that would enhance trainee involvement in the training program and in planning for goal attainment. The result was a graphic presentation of the curriculum similar to a time bar chart. Following these early efforts, an experimental DACUM for a typical occupation was developed in Canada as a model for further application. It was introduced to the NewStart Corporations in 1968 during their planning stages.

The DACUM approach has since been adopted and installed with some modification in a community college and a school of nursing.

Outside the occupational training field, it has been applied by the Corporation in an adult basic education program and (with modification) in the design of a basic literacy program.

B. What It Is

DACUM can be defined as a single-sheet skill profile that serves as both a curriculum plan and an evaluation instrument for occupational training programs.

It is graphic in nature, presenting definitions of the skills of an entire occupation on this single sheet of paper. This discourages treatment of any element of the occupation in isolation. Stated differently, it promotes treatment of any element as part of a larger whole.

It is an analysis of the occupation rather than a curriculum evolving from an analysis. The occupation is subdivided into general areas of competence. Each is then analyzed to identify each skill it contains. The result is independent specification of each of the skills (behaviours) that collectively enable an individual to perform competently in the occupation. These skills are defined quite simply and are structured independently in small blocks on the chart. Each can serve as an independent goal for learning achievement.

A DACUM chart contains a rating scale that accommodates evaluation of skill development achievement for each of the defined skills or behaviours. The chart also serves as a record-keeping system, as all ratings of skills are recorded directly on a copy of the DACUM chart maintained for each trainee. (Adams, 1975.)

The *Training Needs Assessment Checklist* and *DACUM CHART* on the following pages are based on the above, along with the Planning Alcoholism Education Planning Guide (National Center for Alcohol Education, 1982).

DACUM* TRAINING NEEDS ASSESSMENT CHECKLIST
FOR ASSESSMENT AND REFERRAL TASKS

	NEED IMPROVEMENT	OK	STRONG
I. COUNSELLING COMMUNICATIONS†			
– Interviewing			
– Teaching			
– Documenting/Reporting			
1. Demonstrate reflective skills†			
a) Attending†	____	____	____
b) Paraphrasing†	____	____	____
c) Summarizing†	____	____	____
d) Reflects feelings†	____	____	____
2. Demonstrate knowledge and use of relevant forms with emphasis on confidentiality	____	____	____
3. Give feedback†	____	____	____
4. Demonstrate directive skills†			
a) Probing†	____	____	____
b) Confrontation†	____	____	____
c) Interpretation†	____	____	____
5. Handle intoxicated clients	____	____	____
6. Constructive termination of contact	____	____	____
7. Orient client to screening interview	____	____	____
8. Motivate client to participate†	____	____	____
9. Track client (preappointment calls)	____	____	____
10. Conduct screening interview†	____	____	____
11. Inform client of resources available†	____	____	____
12. Communicate screening observations to client	____	____	____
13. Identify client/counsellor/attitudinal barriers†	____	____	____
14. Orient client to assessment/referral process†	____	____	____

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*"DACUM" refers to "Developing a Curriculum" (Adams, 1975). Also, National Center for Alcohol and Education (1982).
Note: † items are covered in ACT

		NEED IMPROVEMENT	OK	STRONG

I. COUNSELLING COMMUNICATIONS†
(Cont'd.)

		NEED IMPROVEMENT	OK	STRONG
15.	Conduct assessment interview(s)†	____	____	____
16.	Educate client re: Life areas†	____	____	____
17.	Conduct supportive (case management) interview(s)†	____	____	____
18.	Participate in case conferences†	____	____	____
19.	Write referral/follow-up reports to treatment services	____	____	____

II. PRACTICAL DRUG CONCEPTS†
  – Identify and evaluate client chemical use
  – Application of a range of chemical dependency theories
  – Application of research findings re: chemical dependency

		NEED IMPROVEMENT	OK	STRONG
1.	Recognize chemical abuse cues†	____	____	____
2.	Identify major categories of chemical abuse†	____	____	____
3.	Demonstrate knowledge and use of relevant paper and pencil tests	____	____	____
4.	Identify major combinations of chemical abuse, e.g., toxic interactions†	____	____	____
5.	Interpret/report findings to next level care	____	____	____
6.	Determine nature and extent of chemical use†	____	____	____
7.	Demonstrate knowledge of major drug actions and interactions†	____	____	____
8.	Provide verbal feedback to client re: assessment/referral information†	____	____	____
9.	Determine consumption risk levels, (e.g., Risk-O-Graph)†	____	____	____
10.	Identify client's perspective of chemical abuse†	____	____	____

Note: † items are covered in ACT

		NEED IMPROVEMENT	OK	STRONG

III. INITIAL INTERVIEW METHODS†
- – Data gathering
- – Interpret findings
- – Synthesis of data

1. Ask: 4 basic questions:†

	NEED IMPROVEMENT	OK	STRONG
a) What chemicals†	____	____	____
b) Amount used†	____	____	____
c) When used†	____	____	____
d) Consequences†	____	____	____
2. Knowledge and understanding of ethical and legal standards	____	____	____
3. Evaluate screening observations†	____	____	____
4. Ability to adapt assessment processes to individual clients†	____	____	____
5. Write psychosocial history†	____	____	____
6. Identify individual client's life area needs†	____	____	____
7. Demonstrate ability to apply functional analysis of client's chemical use†	____	____	____
8. Conduct comprehensive assessment (e.g., ASIST)†	____	____	____
9. Understand elements of case management†	____	____	____
10. Demonstrate ability to analyse relapse potential†	____	____	____
11. Priorize life area needs†	____	____	____

IV. TREATMENT PLANNING STRATEGIES
- – Knowledge of and ability to use community resources
- – Negotiation of treatment plan
- – Selection of interventions

	NEED IMPROVEMENT	OK	STRONG
1. Demonstrate knowledge of assessment/ referral resources†	____	____	____
2. Negotiate next step with client†	____	____	____
3. Identify key significant people in client's life†	____	____	____

Note: † items are covered in ACT

	NEED IMPROVEMENT	OK	STRONG

IV. TREATMENT PLANNING STRATEGIES (Cont'd.)

		NEED IMPROVEMENT	OK	STRONG
4.	Refer client to appropriate resources†	____	____	____
5.	Knowledge of continuum of care e.g.,†			
	a) outpatient†	____	____	____
	b) daycare†	____	____	____
	c) inpatient†	____	____	____
6.	Identify support and follow-up resources†	____	____	____
7.	Demonstrate knowledge of treatment resources and admission criteria†	____	____	____
8.	Involve client in treatment planning process†	____	____	____
9.	Develop relapse prevention plan†	____	____	____
10.	Identify need for crisis intervention†	____	____	____
11.	Summarize client data and interview process information†	____	____	____
12.	Work effectively with treatment personnel	____	____	____
13.	Assist client in problem identification and priorization†	____	____	____
14.	Link client to care systems†	____	____	____
15.	Identify options available†	____	____	____
16.	Identify and document gaps in service	____	____	____
17.	Facilitate coordination among treatment resources	____	____	____
18.	Negotiate a written treatment plan†	____	____	____
19.	Match client to relevant resources†	____	____	____
20.	Monitor client's progress and modify plans	____	____	____
21.	Other (fill in below)			
	_____	____	____	____
	_____	____	____	____
	_____	____	____	____
	_____	____	____	____

All of the above can be organized on one DACUM. (See DACUM CHART on next page.)

_____

Note: † items are covered in ACT

COMPETENCY PROFILE (DACUM) CHART I
ASSESSMENT AND REFERRAL

Column groups: **AREAS OF COMPETENCE** | **CASE IDENTIFICATION** | **CASE MANAGEMENT**

I — COUNSELLING COMMUNICATION

- INTERVIEWING
- TEACHING
- DOCUMENTING/REPORTING

1. Demonstrate reflective skills
   a) Attending
   b) Paraphrasing
   c) Summarizing
   d) Reflects feelings
2. Demonstrate knowledge and use of relevant forms with emphasis on confidentiality
3. Give Feedback
4. Demonstrate directive skills
   a) Probing
   b) Confrontation
   c) Interpretation
5. Handle Intoxicated Clients
6. Constructive termination of contact
7. Orient client to screening interview
8. Motivate client to participate
9. Track client (preappointment calls)
10. Conduct screening interview
11. Inform client of resources available
12. Communicate screening observations to client
13. Identify client/counsellor attitudinal barriers
14. Orient client to assessment/referral process
15. Conduct assessment interview(s)
16. Educate client re: Life areas and chemical abuse
17. Conduct supportive (case management) interview(s)
18. Participate in case conferences
19. Write referral/follow-up reports to treatment serv.

II — PRACTICAL DRUG CONCEPTS

- IDENTIFY & EVALUATE CLIENT CHEM. USE
- APPLICATION OF A RANGE OF CHEM. DEPENDENCY THEORIES
- APPLICATION OF RESEARCH FINDINGS RE: CHEM. DEPENDENCY

1. Recognize chemical abuse cues
2. Identify major categories of chem. of abuse
3. Demonstrate knowledge and use of relevant paper and pencil tests
4. Identify major patterns of chem. of abuse, e.g. toxic interactions
5. Interpret/report findings to next level care
6. Determine nature and extent of chem. use
7. Demonstrate knowledge of major drug actions and interactions
8. Provide verbal feedback to client re: assmnt/referral info.
9. Determine consumption risk levels, e.g. Risk-O-Graph
10. Identify client's perspective of chem. abuse

III — INITIAL INTERVIEW METHODS

- DATA GATHERING
- INTERPRET FINDINGS
- SYNTHESIS OF DATA

1. Ask: 4 basic questions:
   a) What chemicals
   b) Amount used
   c) When used
   d) Consequences
2. Knowledge and understanding of ethical and legal standards
3. Evaluate screening observations
4. Ability to adapt assessment processes to individual clients
5. Write psychosocial history
6. Identify individual client's life area needs
7. Demonstrate ability to apply functional analysis of client's chemical use
8. Conduct comprehensive assessment e.g. A.S.I.S.T.
9. Understand elements of case management
10. Demonstrate ability to analyse relapse potential
11. Priorize life area needs

IV — TREATMENT PLANNING STRATEGIES

- KNOWLEDGE OF AND ABILITY TO USE COMM. RESOURCES
- NEGOTIATION OF TREATMENT PLAN
- SELECTION OF INTERVENTIONS

1. Demonstrate knowledge of assessment/referral resources
2. Negotiate next step with client
3. Identify key significant people in client's life
4. Refer client to appropriate sources
5. Knowledge of continuation of care e.g.
   a) outpatient
   b) daycare
   c) inpatient
   Understanding of policies and procedures manual
6. Identify support and follow-up resources
7. Demonstrate knowledge of treatment resources and admission criteria
8. Involve client in treatment planning process
9. Develop relapse prevention plan
10. Identify need for crisis intervention
11. Summarize data and process information
12. Work effectively with treatment personnel
13. Assist client in problem identification and prioritization
14. Link client to care systems
15. Identify options available
16. Identify and document gaps in service
17. Facilitate coordination among treatment resources
18. Negotiate a written treatment plan
19. Match client to relevant resources
20. Monitor client's progress and modify plans

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APPENDIX A

THE NOMINAL GROUP TECHNIQUE: APPLICATIONS FOR TRAINING NEEDS ASSESSMENT[*]

Nominal Group Technique (NGT) Concept

"A method of generating ideas in a situation where the participants do not fully understand or agree upon the nature of the problem or how to solve the problem". It:

- identifies elements of a problem situation;
- identifies elements of a problem's solution;
- establishes priorities.

NGT Procedure for a Structured Group Meeting

Five to nine individuals sit around a table (or are convened by conference telephone). Initially no talking takes place. Each individual has a sheet of paper with a "nominal question" at the top. This question is the focus of the meeting and is carefully formulated ahead of time in order to generate the required information. For example: "What specific skills and/or knowledge are required to....?"

Phase I

Each individual (independently) writes down as many answers to the question as possible.

After several minutes of controlled and intense word effort, each member, in turn, presents one idea from his/her listing. These ideas are recorded and numbered on flipchart paper by the leader. No discussion or evaluation of the ideas takes place, other than for clarification. The listing continues until no more ideas are offered. This concludes the "nominal" phase of the meeting.

Phase II

Next, the leader conducts a thorough, structured discussion of each recorded idea for clarification and expression of support.

Phase III

From the nominal listing, with independent, private, and silent balloting, the ideas are rank ordered or rated.

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[*]Scott & Deadrick, (1982).

Advantage of NGT

1) Appropriate people can be selected to participate, based on their experience, etc.

2) Cost is low.

3) Maximizes participation and minimizes distraction.

4) Avoids dominance by strong personalities.

5) Encourages a shared commitment to objectives.

6) May be used at many levels.

However, care should be taken to frame nominal questions carefully and clearly. Furthermore, facilitators must be interpersonally skilled.

COUNSELLING
COMMUNICATION SKILLS

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Module 1: ORIENTATION

EXPLAIN THE CONCEPTS:

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COUNSELLING COMMUNICATION SKILLS

Introduction

This Unit is designed to allow counsellors to review and upgrade their abilities by using the following seven basic communication skills in one-to-one interactions with clients:

> ATTENDING
> PARAPHRASING
> REFLECTION OF FEELING
> SUMMARIZING
> PROBING
> INTERPRETING
> CONFRONTATION

On completion of the program, participants will be able to:

– define each skill using their own words;

– recognize when each skill is being practised effectively, and

– demonstrate the ability to use each skill and to integrate all skills appropriately and effectively in a simulated counselling situation.

As counselling is a form of communication, we should begin by describing that process.

Communication involves a SENDER, the TRANSMISSION of a message, and a RECEIVER. The process can be illustrated as follows:

CLIENT ⟶ verbal and nonverbal communication ⟶ COUNSELLOR verbal and nonverbal communication ⟶ CLIENT

And so the process of communication between the client and counsellor in the counselling situation is a continuous two-way sequence.

This sequence of events implies that the counsellor:

(1) *LISTENS*, i.e. receives a message,

(2) *PROCESSES*, i.e. considers the message in combination with previous knowledge and experience;

(3) *RESPONDS*, i.e. delivers a response to the original message.

Listening – is defined as receiving messages from a client by focusing attention on what the client is expressing, both verbally and nonverbally.

Processing – is the complex series of events that take place within the counsellor between his or her listening and responding to the client. Processing may include mentally cataloguing data, categorizing, comparing, hypothesizing on significance, contemplating implications, and selecting a response on the basis of feelings, self-acceptance, and other factors that influence judgment and performance.

Responding – is the verbal or nonverbal reply that the counsellor makes as a result of processing the information received from listening to the client.

In this segment of the program, we will focus on the counsellor's role in the area of listening and responding. The second step, processing, will be addressed in the "Practical Drug

Concepts" Unit of this program in relation to drug and alcohol effects; and in the "Treatment Planning" Unit in relation to drug and alcohol treatment.

From the counsellor's perspective, there are many ways to classify one's responses to a client. For the purposes of this program, counsellor responses have been clustered into two categories – REFLECTIVE SKILLS and DIRECTIVE SKILLS.

Reflective responses are those counsellor responses which do not add new material to what the client has said and thus reflect information that has been received by the counsellor back to the client. *Directive* skills are those counsellor responses that either add new material to what the client has told the counsellor, or explicitly direct the client to explore a specific topic or a new perspective at greater length. This basic communication Unit comprises four reflective counselling skills and three directive counselling skills.

The four reflective counselling skills as defined in this program are:

Attending – Demonstration of the counsellor's concern for and interest in the client by eye contact, body posture, and accurate verbal following.

Paraphrasing – A counsellor statement that mirrors the client's statement in exact or similar wording.

Reflection of Feeling – The essence of the client's feelings, either stated or implied, as expressed by the counsellor.

Summarizing – A brief review of the main points discussed in the session to ensure continuity in a focused direction.

The three directive counselling skills* as defined in this program are:

Probing – A counsellor response phrased as an open-ended question which directs the client to explore a specific subject at greater length.

Interpretation – A counsellor response directed at helping the client explore an alternative perspective on a problematic issue.

Confrontation – A counsellor response which constructively illustrates the discrepancies that a client is presenting.

The seven skills covered in this training program were selected not only because of their fundamental nature but also because they represent the core of basic skills necessary for the largest number of counsellor activities in one-to-one client interactions. The major activities in one-to-one client interactions can be expressed in a variety of ways. In one such listing, the counsellor:

    (1)   establishes and maintains a climate for counselling;

    (2)   interviews the client to gather case history information;

    (3)   provides safeguards for maintaining confidentiality and ethical standards;

    (4)   prepares and uses necessary client reports and records;

    (5)   seeks consultation on the client's case when needed;

    (6)   negotiates an individual treatment plan that is tailored to, and acceptable to, the client;

    (7)   plans strategies for intervening in the client's crisis situations outside the counselling setting;

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*Self-disclosure is another important directive counselling skill. However, space does not permit an adequate discussion of it here. A good rule of thumb is: disclose only that which will help the client.

(8) increases the client's understanding of the severity of the abuse by explaining the nature of alcoholism or drug abuse as a socio-behavioural-physical problem;

(9) informs and assists the client in establishing necessary contacts with community services;

(10) coordinates involvement of other resource persons in accordance with a mutually acceptable individual treatment plan for the client;

(11) increases the client's ability to recognize the possible need for counselling assistance in the future;

(12) prepares for and conducts aftercare activities with the client;

(13) evaluates client progress and assists him/her in doing the same so that individualized treatment plan goals can be redefined if necessary;

(14) given the client's expressed desire to discontinue participation in the treatment process, the counsellor leads the client in a review of the accumulated gains of the treatment process.

By matching the seven skills with the list of activities, it is apparent that, regardless of what other skills may be required, Attending, Paraphrasing, Reflection of Feeling, and Summarizing are essential to "establishing and maintaining a climate for counselling", which is fundamental to and part of all the other activities. In addition, Probing, Interpreting and Confrontation are critical to above Activities 2, 6, 11, 12, 13, 14 and are called for in certain phases of above Activities 5, 7, 8, 9, and 10.

Other important aspects of the counsellor/client interaction include the qualities of genuineness, warmth, empathy, immediacy, congruence, concreteness and respect. These are not skills, but rather conditions which the counsellor can create partially through the use of the basic communication skills. These conditions are not addressed directly in the training program but will be discussed where appropriate. They should also be addressed in selecting appropriate counsellors/trainees, in terms of constructive attitudes towards potential clients.

In summary, this training program focuses on the presentation and practice of seven basic counselling skills. These are not the only skills a counsellor uses in the counselling situation; however, they are essential in establishing a foundation of client self-awareness and mutual understanding between client and counsellor. Their use in a counselling session or in communication with colleagues, family, and others will help the counsellor to:

– listen effectively to find out what the other person's situation or problem is;

– let the other person know that the counsellor is really hearing and understanding him/her;

– check out with the other person that the counsellor's perception of the situation or problem is accurate, and

– assist the other person in his or her perception and understanding of self, situation, and possibilities for change.
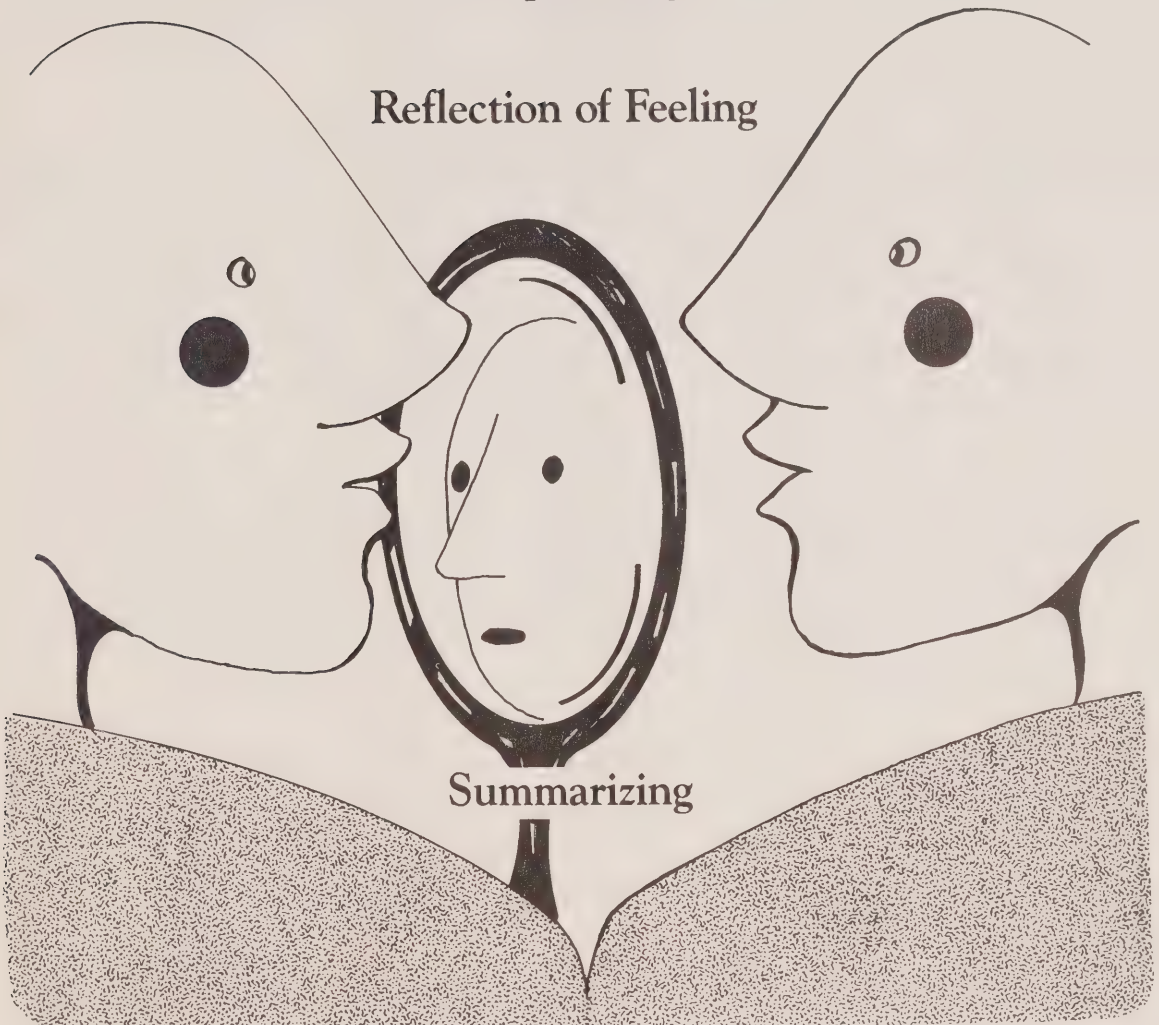
Module 2: REFLECTIVE COUNSELLING SKILLS

Attending

Paraphrasing

Reflection of Feeling

Summarizing

Module 2: REFLECTIVE COUNSELLING SKILLS

Although these seven counsellor response skills are presented one at a time, they are clustered into reflective and directive counselling skills. In this program, participants will first practise reflective skills, then integrate the reflective skills with directive skills.

The process will involve large group discussions, small group exercises, skills demonstrations, and practice through role played counselling simulations.

Practice

A complex set of skills cannot be learned, much less mastered without continuous practice. Fortunately, day-to-day living offers many opportunities to practise these basic, vital communication skills. Those who are introduced to the skills described above are encouraged to practise, monitor and examine them as often as the opportunities permit. Only through doing this can one approach mastery of these basic elements of constructive communication, and avoid their "getting rusty". This manual can help in the process. Keep it and use it!

REFLECTIVE SKILLS

Reflective skills are those counsellor responses which do not add new material to what the client has already stated, nor do they explicitly direct the client to explore areas of his/her life situation that he/she hasn't already expressed to the counsellor. As the name "reflective" implies, these responses reflect messages that the client is giving to the counsellor. Categories of reflective skills are: *Attending*; *Paraphrasing*; *Reflection of Feeling*; *Summarizing*. Reflective skills should always be "checked out" with the client to ensure that the counsellor is not misunderstanding the messages he/she is receiving from the client. Following are explanations of those skills involved in reflective responding.

ATTENDING

Attending is fundamental to the use of all other counselling skills. As used here, attending implies a concern by the counsellor with all aspects of the client's communication. It includes listening to the verbal content, and observing the nonverbal cues to the feeling(s) that accompany the verbal communication, and then communicating back to the client the fact that the counsellor is paying attention.

Purposes of Attending

(1) It encourages the client to continue expressing his/her ideas and feelings freely.

(2) It allows the client to explore ideas and feelings in his/her own way and thus provides the client with an opportunity to direct the session.

(3) It can give the client a sense of responsibility for what happens in the session by enabling him/her to direct the session.

(4) It helps the client relax and be comfortable in the counselling session.

(5) It contributes to the client's trust of the counsellor and sense of security, through communicating interest, respect, and attention.

(6) It enables the counsellor to draw more accurate inferences about the client, through careful observation.

Components of Attending

Effective attending has two components:

(1) listening and observing;

(2) communicating to the client that listening and observing are going on.

The first component of Attending behaviour is listening effectively and observing carefully. For many people, listening is a difficult task to learn. Although society does place great emphasis on spoken exchanges, many people have not learned to listen effectively. Often, people may think they are listening when they are actually thinking about something else or are debating a subject in their head while waiting for the other person to pause so that they can present some comment of their own. A client can usually sense when the counsellor is listening with "half an ear".

Effective listening by itself, however, is not enough. Counselling occurs in a face-to-face situation where both participants watch, as well as listen to, each other. The difference in information gathered from seeing and hearing as opposed to hearing alone is illustrated vividly by contrasting television with radio.

The counsellor learns much about the feeling of the client through observation. Frequently, nonverbal behaviour that expresses feelings may appear to alter or even negate verbal messages. It is common for people to communicate much more than they intend by their body language. As a matter of fact, the nonverbal message is more likely to transmit the real message than the spoken words – for example, a facial expression showing disgust may contradict the statement, "I'm not bothered by the thought of a drunken woman."
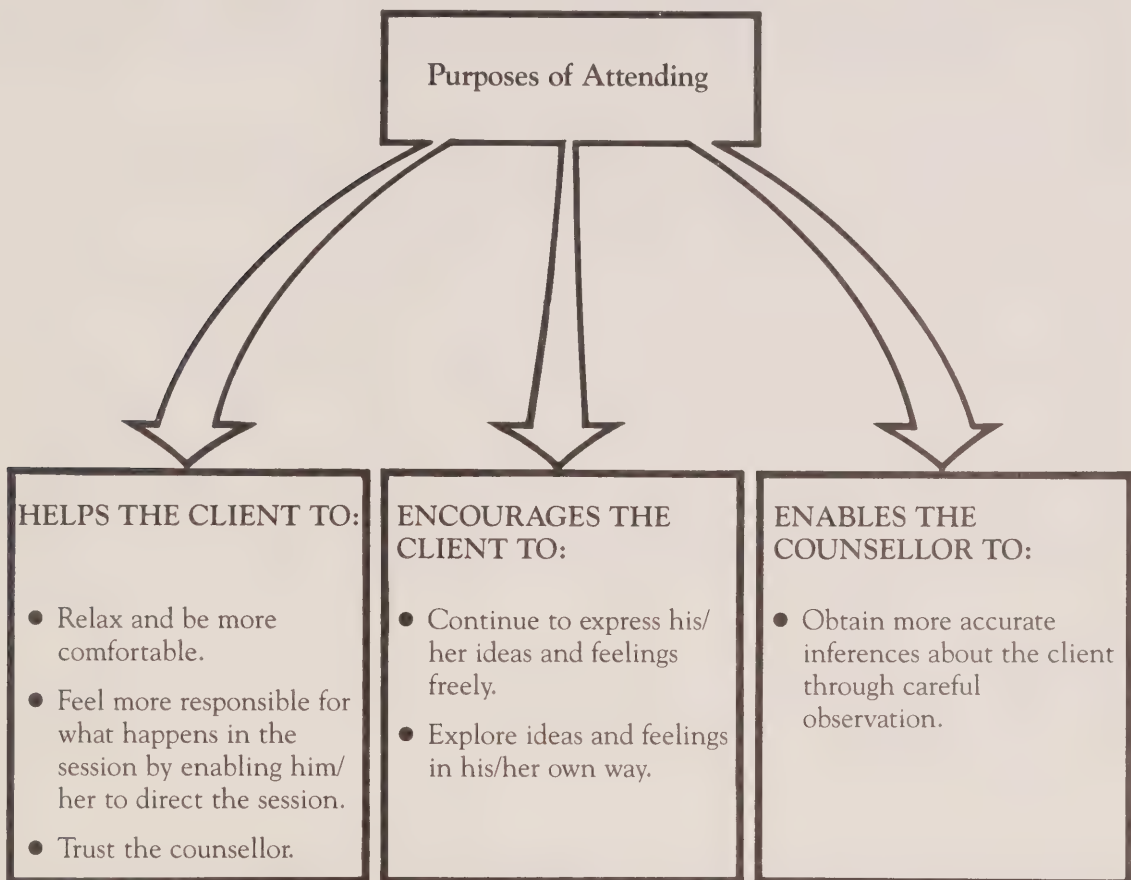
Conversely, many of the skills, attitudes, and feelings of the counsellor are conveyed to the client through nonverbal behaviour such as facial expressions, posture, eye contact and gestures. The first component of Attending occurs when the counsellor stays attuned to what the client is expressing verbally and nonverbally. He/she listens closely and observes carefully.

The second component of Attending behaviour is letting the client know that he/she is really being heard. The counsellor communicates his/her attentiveness to the client generally through three methods:

(a) *Eye Contact* – The counsellor should initiate and maintain eye contact with the client. Strong impressions, favourable and unfavourable, are formed depending on the kind and amount of eye contact. In ordinary social interaction, it is considered courteous to look at the person with whom one is speaking. In counselling, this behaviour is almost imperative. However, in some cases, continuous eye contact might cause the client to feel uncomfortable, as could a fixed stare or an intense gaze. Varied use of eye contact is the most effective and natural behaviour for the counsellor and the most likely to put the client at ease. It is important to note that these comments on eye contact are not applicable to all cultures. For instance, maintaining direct eye contact is a hostile act to some Native Americans and may be taken as a lack of respect by some Orientals.

(b) *Posture* – Body language reveals a great deal about people; posture and gestures convey distinct messages. Impressions of others are formed even from the way they sit. The counsellor wants to communicate to the client, by his/her body posture, that he/she is interested. An upright seated position with the upper body leaning slightly forward is generally considered to convey attentiveness, but the counsellor should adopt a posture in which he/she will feel relaxed and comfortable. The first position the counsellor assumes won't necessarily be the only one. The counsellor will undoubtedly shift positions during the counselling session, for comfort and as a reflection of his/her feelings.

Again, a word of caution is offered regarding cultural differences in acceptable Attending. In some cultures, sitting too close to a client might be considered offensive or threatening; sitting too far away might convey detachment or withdrawal. Individuals vary in the amount of distance or closeness they need. By watching how the client uses space in relation to him/her, the counsellor will probably have an indication of what is comfortable for the client.

(c) *Accurate Verbal Following* – The counsellor communicates to the client that listening and observing are occurring by means of verbal responses. The most important characteristic of accurate verbal responses is that they relate directly to what the client is expressing. This means that the counsellor takes his/her cues from the client and indicates involvement by simply nodding, using encouraging phrases such as "um-hm" or "I see", repeating key words, or posing one-word questions, such as "Oh?" or "Yes?".

Purposes of Attending		
HELPS THE CLIENT TO:	**ENCOURAGES THE CLIENT TO:**	**ENABLES THE COUNSELLOR TO:**
• Relax and be more comfortable. • Feel more responsible for what happens in the session by enabling him/her to direct the session. • Trust the counsellor.	• Continue to express his/her ideas and feelings freely. • Explore ideas and feelings in his/her own way.	• Obtain more accurate inferences about the client through careful observation.

Later in this training program, the counsellor will practise other reflective skills (e.g. Paraphrasing, Reflection of Feeling, and Summarizing) that convey to the client that the counsellor has listened and observed. At this point in the program, the counsellor can demonstrate accurate verbal following by offering minimal verbal responses, making head movements, and staying with the topic.

Summary of Attending

In Attending, the counsellor's goal is to listen effectively, to observe the client, and to communicate his/her interest and attentiveness through direct eye contact, relaxed body posture, and accurate verbal following. The skill of Attending is the foundation on which all the other skills in this program are built.

PARAPHRASING

Paraphrasing is a reflective counselling skill that restates the content of the client's previous statement. Paraphrasing concentrates primarily on verbal content. In Paraphrasing, the counsellor reflects to the client the verbal essence of his/her last comment or last few comments. Sometimes Paraphrasing may involve simply repeating the client's own words, perhaps emphasizing one word in particular. More often, Paraphrasing is using words that are similar to the client's, but fewer in number.

Paraphrasing and Reflection of Feeling are very similar and therefore are easy to confuse. In both skills, the counsellor must identify the client's basic message, either cognitive or affective (pertaining to feeling or emotion), and give that message back to the client using his/her (the counsellor's) own words.

The distinguishing feature between Paraphrasing and Reflection of Feeling is the focus of the counsellor's response. Paraphrasing focuses on the words the client is speaking. Reflection of Feeling focuses on the associated feeling or emotion as expressed in the client's tone of voice, rate and volume of speech, posture, and other nonverbal behaviour as well as verbal content.

Purposes of Paraphrasing

(1) It communicates to the client that the counsellor understands or is trying to understand what he/she is saying. Paraphrasing can thus be a good indicator of accurate verbal following.

(2) It sharpens a client's meaning to have his/her words rephrased more concisely and often leads the client to expand his/her discussion of the same subject.

(3) It often clarifies confusing content for both the counsellor and the client. Even when Paraphrasing is not accurate, it is useful because it encourages the client to clarify his/her remarks.

(4) It can spotlight an issue by stating it more succinctly, thus offering a direction for the client's subsequent remarks.

(5) It enables the counsellor to verify his/her perceptions of the verbal content of the client's statement.

Components of Paraphrasing

Paraphrasing has two components:

(1) determining the basic message, and

(2) rephrasing.

The counsellor uses his/her judgment to determine the basic message that is being expressed in the client's verbal content. Much of the time clients tend to speak in short paragraphs. They seldom state a single thought and wait for a reply. So the counsellor must attend to all of the client's verbal content, but decide on the basic message being expressed in the "paragraphs".

After the counsellor determines the basic message to be responded to, he/she attempts to give this content back to the client in a more precise way by rephrasing it. The counsellor may want to combine several of the client's related comments into one response to the client.

To paraphrase effectively, then, the counsellor determines the basic message from the content and rephrases it, usually in similar, but fewer words. For example, "What I hear you saying is, it has been a difficult week", or "you don't understand her".

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                    │   Purposes of Paraphrasing  │
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HELPS THE CLIENT TO:	ENCOURAGES THE CLIENT TO:	ENABLES THE COUNSELLOR TO:
• Realize that the counsellor understands or is trying to understand what he/she is saying. • Get a sense of direction.	• Expand his/her discussion of the same subject. • Clarify his/her remarks.	• Verify his/her perceptions of the verbal content of the client's statements. • Spotlight an issue.

Checking Out

To minimize the possibility of the counsellor's letting his/her assumptions distort what the client is saying, the counsellor should get in the habit of checking out his/her Paraphrasing. This can be done by adding phrases such as, "Is that right?", "Am I correct?", or "Have I heard you correctly?" to the paraphrase.

This procedure will usually evoke a response from the client, and the counsellor can then judge whether he/she is making assumptions or is accurately attending to the client. Checking out may not be necessary, however, if the client is clearly indicating agreement either verbally or nonverbally.

Assessing the Outcome of Paraphrasing

How effectively a counsellor has used Paraphrasing can best be judged by the client's next response after a paraphrase. If the paraphrase is effective, the client may indicate agreement by a word or gesture and may continue to talk further on the same subject.

Sometimes the counsellor will not succeed in accurately distilling the client's comments, and the client may reply, "No, that's not what I meant." When this occurs, the counsellor's attempt at Paraphrasing has still been useful because it allows the counsellor to see immediately that he/she has erred either in determining the basic message or in rephrasing the content.

In other instances the client may confirm the accuracy of the counsellor's paraphrase but, having heard his/her meaning expressed in different words, decide to modify or even reverse the meaning entirely to reflect a changed point of view.

Each of these outcomes can be regarded as evidence that the counsellor's paraphrase has been effective.

Summary of Paraphrasing

To paraphrase is to determine the basic message in the client's cognitive statements and concisely rephrase it. The rewording should capture the essence of the cognitive verbal content. Occasionally, an exact repetition of the client's remarks may be appropriate paraphrase. More commonly, the counsellor determines and rephrases the basic message of the verbal content using similar, but fewer, words.

REFLECTION OF FEELING

Dealing with feelings and emotions, one's own or others', is probably the most difficult part of human relations. One cause of this difficulty is that the dominant Canadian culture does not value open and free expression of feelings and emotions.
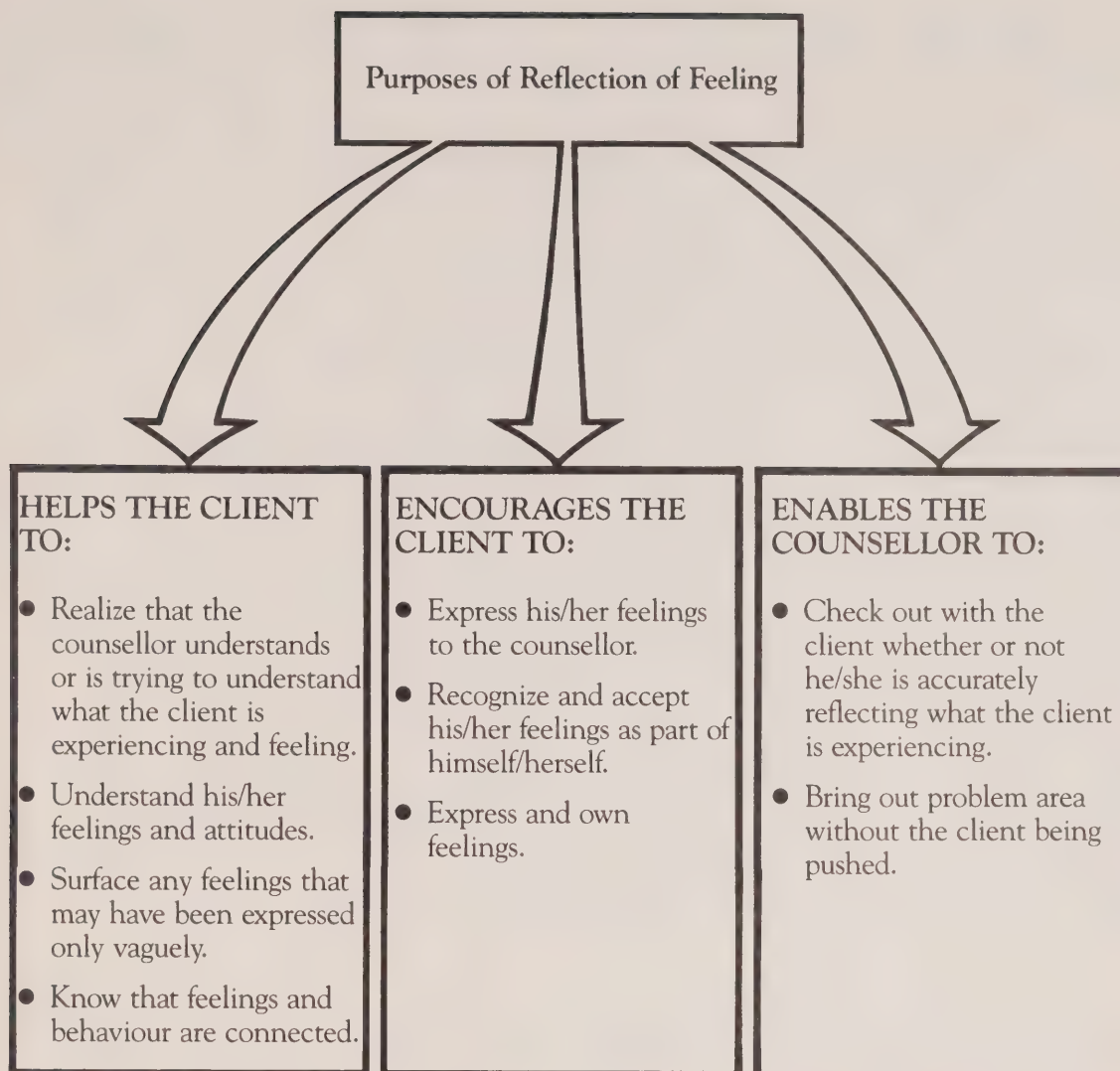
At an early age, we learn to control, mask, or deny our feelings. Unfortunately, with most of us, this process is learned well and reinforced continuously in our schooling. Through primary emphasis on intellectual achievement, we are conditioned to restrain, and even deny, our emotions. However, denied or suppressed feelings do not just disappear. Depending on the intensity of the feelings and how long they have been suppressed, they manifest their presence both psychologically and physically in such ways as difficulty in communicating with others, depression, fatigue, tension headaches and psychosomatic illness. A more constructive approach is to recognize that feelings and emotions exist, accept them as part of ourselves, and learn to express them in ways that promote individual growth and mutually satisfying relationships.

In counselling, we must communicate with the client not only on the factual or cognitive level (meaning events, people, things), but also on the affective level (meaning feelings about events, people, things). Frequently, we may have as clients people who have controlled, inhibited, or denied their feelings and emotions for years. One of our tasks is to help them understand that it is acceptable, even necessary, to be aware of and express their feelings in the counselling relationship. The ability of the counsellor to transmit the message is based on the assumption that the counsellor can get in touch with, identify, and express his/her own feelings. Our primary focus here is on helping the client to become aware of, identify, and express his/her feelings.

An important concept to understand with regard to reflection of feeling is empathy, which has been identified as one of the essential conditions in counselling. Empathy, in everyday language, means putting oneself in the other person's shoes. More formally, it might be defined as the counsellor's attempting to perceive what is happening in regard to the client's feelings and to communicate this perception to the client. Reflection of Feeling is one of the ways empathy can be communicated.

Purposes of Reflection of Feeling

(1) It conveys to the client that the counsellor understands or is trying to understand what the client is experiencing and feeling. This empathy for the client usually reinforces the client's willingness to express feelings to the counsellor.

(2) It clarifies the client's feelings and attitudes by mirroring them in a nonjudgmental way.

(3) It brings to the surface feelings of the client that may have been expressed only vaguely.

(4) It gives the client the opportunity to recognize and accept his/her feelings as part of himself/herself. Sometimes the client may refer to "it" or "them" as the source of a problem, when he/she really means "I was feeling angry".

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│      Purposes of Reflection of Feeling      │
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HELPS THE CLIENT TO:	ENCOURAGES THE CLIENT TO:	ENABLES THE COUNSELLOR TO:
• Realize that the counsellor understands or is trying to understand what the client is experiencing and feeling. • Understand his/her feelings and attitudes. • Surface any feelings that may have been expressed only vaguely. • Know that feelings and behaviour are connected.	• Express his/her feelings to the counsellor. • Recognize and accept his/her feelings as part of himself/herself. • Express and own feelings.	• Check out with the client whether or not he/she is accurately reflecting what the client is experiencing. • Bring out problem area without the client being pushed.

(5)   It verifies the counsellor's perceptions of what the client is feeling. That is, it allows the counsellor to check out with the client whether or not the counsellor is accurately reflecting what the client is experiencing.

(6)   It can bring out problem areas without the client feeling pushed.

(7)   It helps the client infer that feelings and behaviour are connected.

(8)   It gives permission to express and own feelings.

Components of Reflection of Feeling

Reflection of Feeling consists of two components:

(1)   identification, and

(2)   formulation.

The counsellor must first identify the basic feeling(s) being expressed verbally or nonverbally by the client. To be able to identify feelings in clients, a counsellor must be able to recognize feelings in himself/herself. Although the counsellor can't feel the client's feelings, he/she can infer what they might be by processing the verbal and nonverbal information the client is communicating. The counsellor matches the information he/she gains with his/her experiences

in order to label the feelings the client seems to be experiencing. Since the counsellor has experienced feelings such as joy, anger, pain, fear, and boredom, he/she can remember how they felt.

To recognize or be aware of feelings in the client, the counsellor attends to both verbal and nonverbal cues. When he/she is listening effectively to the client's statements, the counsellor may perceive feelings that are either directly expressed or implied. Sometimes the verbal indications of feelings may not be as straightforward as they seem. Often "I think" and "I feel" are used interchangeably, although they have different meanings, particularly in counselling. For example, if a client says, "I feel overjoyed at the news," the counsellor can infer that the client was happy. However, if the client says, "I feel he is too strict," the counsellor cannot reliably infer what the client feels, but only what he/she thinks.

Distinct messages of emotional content also will come from nonverbal cues. Nonverbal indicators of feeling include such things as head and facial movements, posture, gestures, and voice tone and quality. Some examples of specific nonverbal cues are lowered head, folded arms, restlessness, crying, and slowness of speech.

Think back for a moment. When you're depressed, how does your voice sound? When you're angry, what happens to your face, mouth, eyes, jaw and voice? When you're afraid, what happens to your eyes, your body posture, your gestures? Of course, different people will display different degrees and amounts of emotional intensity in different ways. Only after observing and interacting with a person over time can anyone begin to decide what the person's nonverbal behaviour might really be saying about how he/she is feeling.

In general, though, the counsellor can be alert to such facial and body expressions as smiles, eyes widening or narrowing, worry wrinkles, drooping shoulders, or tightly clenched hands. Voice quality is an important area to attend to for signs of emotion. Loudness or softness, changes in tone or inflection, and emphasis on one word are indications of feelings. Sometimes the client may convey conflicting messages with his/her verbal and nonverbal behaviour. The words may be "I'm not upset" when the hands are shaking and the face is red.

Thus, in identifying feelings, the counsellor attempts to enter the client's frame of reference by drawing on his/her own experiences with feelings. The counsellor must identify the feelings the client is communicating before he/she can reflect them accurately to the client.

The second component of effective Reflection of Feeling is to formulate a response that captures the essence of the feeling expressed by the client. Although the counsellor tries to understand and identify the client's feelings as well as he/she can, it is not possible to be the client; so any conclusions drawn should be considered tentative and presented as tentative reflections. By remaining tentative and open-minded in formulating verbal responses, the counsellor avoids dogmatic sounding responses that might alienate the client if they are inaccurate.

Examples of appropriate phrases with which a counsellor might begin a Reflection of Feeling response are:

It seems that you feel …
Are you saying that you feel …
You seem to feel …
Is it possible that you feel …
I'm picking up that you feel …
You appear to be feeling …
Perhaps you're feeling …
I sense that you feel …

Often, counsellors find Reflection of Feeling one of the harder skills to master. Some common errors counsellors tend to make in using this skill follow in the next section. These errors may also occur in using some of the other skills in the program.

Common Errors in Formulating Reflection of Feeling Responses

(1) **Stereotypic Language** – The counsellor can fall into a pattern of always beginning reflections in the same way with a phrase such as "you feel ...". Some of these phrases were listed above as appropriate, but the counsellor should avoid using any one of them too often. The counsellor should vary his/her style of reflecting.

(2) **Timing** – Sometimes the inexperienced counsellor attempts to reflect feelings after every statement the client makes. This can give an impression of insincerity and may dilute the effect of the technique. At the other extreme, the counsellor waits until the client has finished a long series of comments and tries to reflect many feelings in one response. Another error in timing involves pauses. Counsellors often don't wait out pauses. Long pauses can mean that the client is trying to say things that are difficult for him/her to say, but the uncomfortable counsellor may jump in and respond immediately, in effect interrupting and breaking off the client's struggle to express a complex or painful thought or feeling.

(3) **Too-Shallow or Too-Deep Responses** – The counsellor should strive to feed back to the client the essence of what he/she is expressing. The counsellor should avoid either reflecting a feeling at a level that is more intense than the client is feeling or taking away from the client's meaning by merely labelling the feeling. The goal is to communicate to the client that he/she is understood on the level where he/she is. For example, a client may say, "I feel bad. I had some drinks at the office party last night after I promised myself I wouldn't." A too-shallow response from the counsellor might be, "You mean you're sorry." A too-deep response might be, "You feel really guilty about your drinking."

Checking Out

Checking out perceptions is as important in Reflection of Feeling as it is in Paraphrasing, even though the Reflection of Feeling is phrased tentatively. The addition of a questioning phrase, usually at the end of the Reflection of Feeling statement, will ensure that the counsellor is not making unfounded assumptions about the client. For example, "I sense that you feel discouraged today. Is that right?"

Assessing the Outcome of Reflection of Feeling

In Reflection of Feeling, as in Paraphrasing, the effectiveness of the activity can be determined by the client's response. The client may confirm or disclaim the reflection. If the reflection is accurate, the client is more likely to continue discussing the feeling reflected. An inaccurate reflection will often bring a correcting response from the client, which results in clarification. In either case, the net result of Reflection of Feeling responses made by the counsellor should be an increased focus on feelings by the client as he/she perceives that discussing feelings is acceptable in counselling.
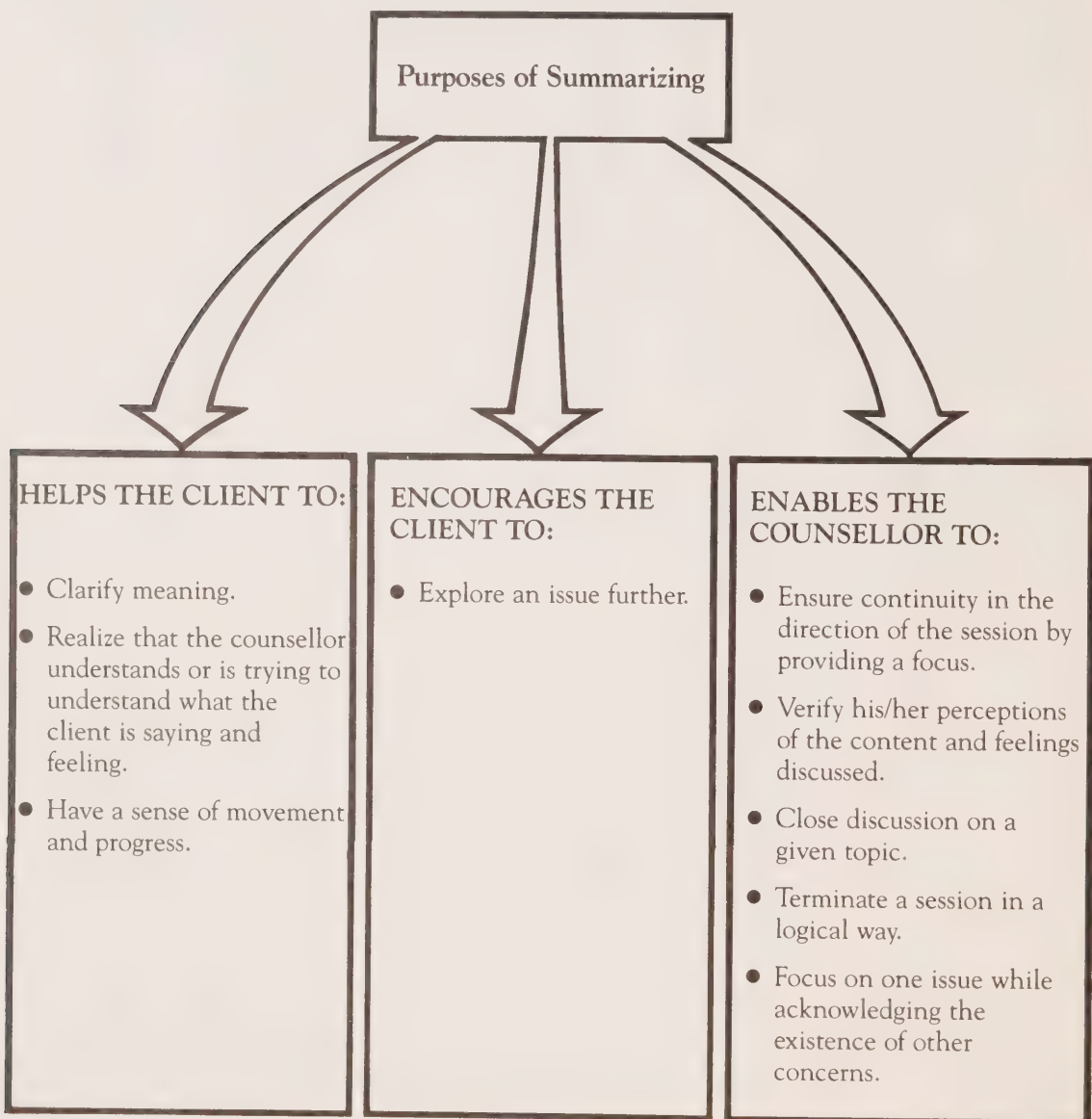
Summary of Reflection of Feeling

Reflection of Feeling involves identifying the essence of the feelings the client is expressing and formulating a response that indicates that the counsellor understands. Usually the counsellor offers fresh words that capture the basic verbal or nonverbal feeling message of the client.

SUMMARIZING

Summarizing is the tying together by the counsellor of the main points discussed in a counselling session. Summarizing can focus on both feelings and content. It is appropriate after a discussion of a particular topic within the session or as a review at the end of the session of the principal issues discussed. In either case a summary should be brief, to the point, and without new or added meanings.

In many respects, Summarizing is similar to, or an extension of, Paraphrasing and Reflection of Feeling in that the counsellor seeks to determine the basic meaning being expressed in verbal content or effect and give these meanings back to the client in fresh words. Summarizing differs from Paraphrasing and Reflection of Feeling primarily in the span of time it is concerned with. In Paraphrasing, a statement or brief paragraph occurring over a short period of time is rephrased. In summarizing verbal content, several of the client's statements, the entire session, or even several sessions are pulled together.

Purposes of Summarizing

HELPS THE CLIENT TO:

- Clarify meaning.
- Realize that the counsellor understands or is trying to understand what the client is saying and feeling.
- Have a sense of movement and progress.

ENCOURAGES THE CLIENT TO:

- Explore an issue further.

ENABLES THE COUNSELLOR TO:

- Ensure continuity in the direction of the session by providing a focus.
- Verify his/her perceptions of the content and feelings discussed.
- Close discussion on a given topic.
- Terminate a session in a logical way.
- Focus on one issue while acknowledging the existence of other concerns.

In Reflection of Feeling, the counsellor responds to the last feeling or feelings expressed or displayed. In summarizing feelings, the counsellor reviews numerous feelings expressed or displayed over a longer period of time.

Purposes of Summarizing

(1) It can ensure continuity in the direction of the session by providing a focus.

(2) It can clarify a client's meaning by having his/her scattered thoughts and feelings pulled together.

(3) It often encourages the client to explore an issue further once a central theme has been identified.

(4) It communicates to the client that the counsellor understands or is trying to understand what the client is saying and feeling.

(5) It enables the counsellor to verify his/her perceptions of the content and feelings discussed or displayed by the client during the session. The counsellor can check out whether he/she accurately attended and responded without changing the meanings expressed.

(6) It can close discussion on a given topic, thus clearing the way for a new topic.

(7) It provides a sense of movement and progress to the client by drawing several of his/her thoughts and feelings into a common theme.

(8) It can terminate a session in a logical way through review of the major issues discussed in the entire session.

(9) Summarizing can be useful in "parcelling" several issues that a client may present. Summarizing allows the counsellor to focus on one issue while acknowledging the existence of the concerns which may be dealt with subsequently. This is especially useful with new clients, or clients who tend to "flood" the counsellor with information and concerns.

Components of Summarizing

Accurate Summarizing has two components:

(1) selection of key point, and

(2) tying together.

The counsellor uses his/her judgment to select the key points discussed. As the counsellor picks out the highlights of content and feelings, general themes usually begin to emerge. When deciding what material to summarize, the counsellor should note consistent and inconsistent patterns that have evolved in the session. For example, the client may keep coming back to one particular issue, implicitly emphasizing its importance, or the client may seem to contradict himself/herself by making conflicting statements at different times during the session.

After selecting the principal points discussed or displayed, the counsellor attempts to tie together these points and to feed them back to the client in a more concise way.

In drawing together the content and feelings, the counsellor should avoid adding his/her ideas, which could well be assumptions. The idea is to give back to the client essentially what he/she has said, concisely, using fresh words.

Assessing Outcomes of Summarizing

The outcome of a summarization depends to a large extent on where in the counselling session it occurs. If the summarizing of a particular topic occurs during the session, it is likely to encourage the client to talk further. If Summarizing occurs at the end of the session, it is more likely to terminate further discussion.

How effectively a counsellor has summarized the essence of the verbal content and feelings the client has expressed can best be determined by the client's response to the summary. The client may affirm that the counsellor has tied together points already discussed and, depending on where in the session the summary is made, continue to explore the topic, begin a related or new topic, or accept the counsellor's remarks as a wrap-up of the session.

Sometimes the counsellor may not have accurately pulled together the essential content and feelings of the client, or may have added assumptions of his/her own to the exchange. In that case the client might say "That isn't quite what I said", or "I agree with that except for ...". The counsellor and client can then resolve areas in question before proceeding or ending the session.

As with Paraphrasing and Reflection of Feeling, the counsellor should make a practice of checking out the accuracy of a summary with the client to minimize the chances of making unwarranted assumptions.

Examples of Summarizing

To a divorced woman exploring problems that she is having with a teenage son, who is drinking heavily:

As I understand what you've been saying during the past few minutes, you seem to be struggling with three possible ways to handle the situation:

(1)   you might continue trying to reason with your son yourself;

(2)   you might ask his father to help you deal with the boy;

(3)   you might stop discussing the problem with your son and punish him by taking away his privileges.

At the end of a session with a male client:

Let's take a look at what we've covered in today's session. It sounds like you've felt inadequate in dealing with several areas of your life – your family, your job, and now your drinking.

Summary of Summarizing

To summarize is to select the key points or basic meanings from the client's verbal content and feelings and succinctly tie them together. The summarization should accurately reflect the essence of the client's statements and feelings and should not include assumptions of the counsellor. Summarizing then is a review of the main points already discussed in the session to ensure continuity in a focused direction.

Module 3: DIRECTIVE COUNSELLING SKILLS

Constructive
Confrontation
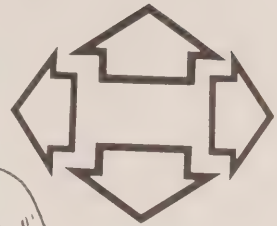
Interpretation

Probing

Module 3: DIRECTIVE COUNSELLING SKILLS

DIRECTIVE SKILLS

Directive counselling skills are those types of responses which explicitly direct the client to examine or consider a specific issue or viewpoint. In this process, new material may or may not be added by the counsellor.

Directive counselling skills included in this program are: Probing, Interpretation, and Confrontation. Usually, directive skills are preceded by a reflective skill, e.g.:

> "It seems to me that you are pretty angry at your son." (counselling reflective skill – Reflection of Feeling)

> "Yeah" (client response)

> "Could you tell me more about how you and your son started arguing about the car?" (counselling directive skill – Probing)

> Following are explanations of the three directive counselling skills in this program.

PROBING

If Attending is the key reflective skill for relationship building, then Probing is the key directive skill involved in problem solving.

Definition of Probing

Probing is a counsellor's use of a question or statement to direct the client's attention inward to explore his/her situation in more depth. A Probing question, sometimes called an "open-ended question", requires more than a one-word (yes or no) answer from the client.

When phrased as a statement, Probing contains a strong element of direction by the counsellor: for example, "Tell me more about your relationship with your parents," or "Suppose we explore a little more your ideas about what an alcoholic is."
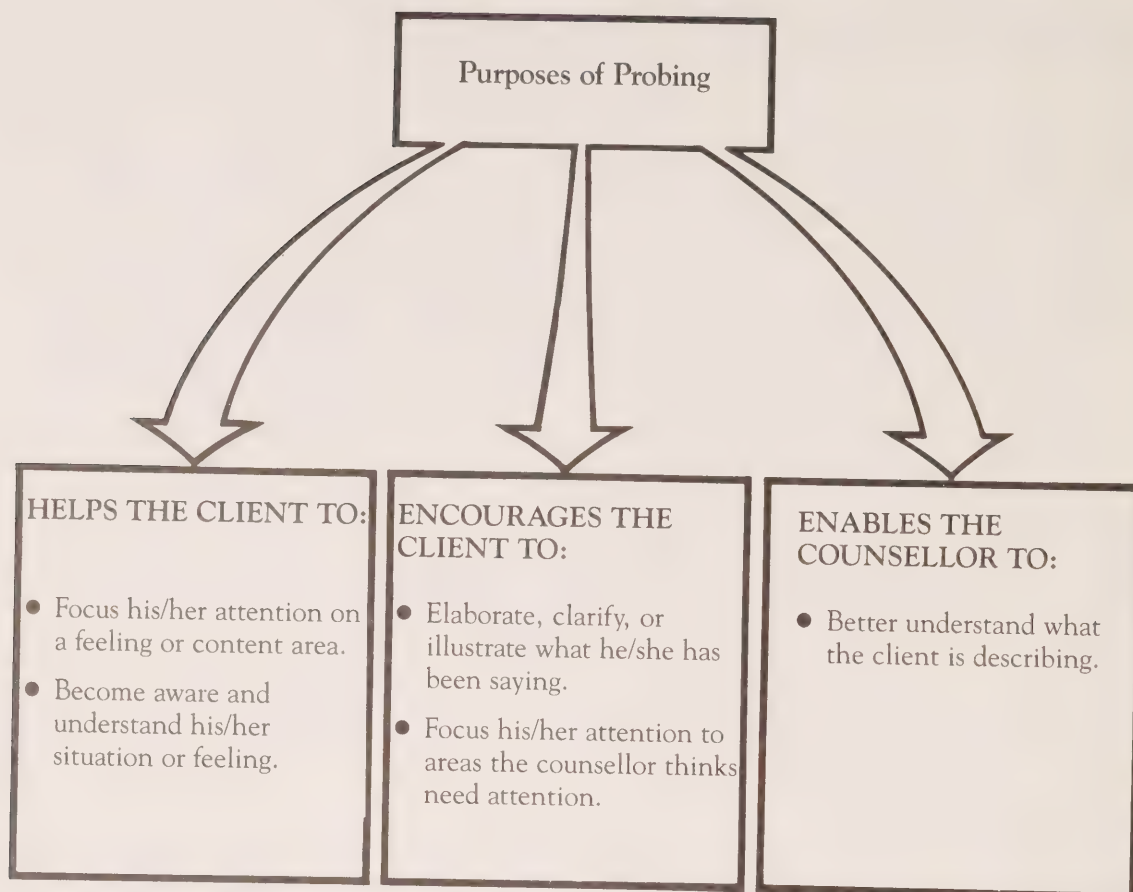
Purposes of Probing

(1) It can help focus the client's attention on a feeling or content area.

(2) It may help the counsellor better understand what the client is describing by giving him/her more information about the client's situation.

(3) It may encourage the client to elaborate, clarify, or illustrate what he/she has been saying.

(4) It sometimes enhances the client's awareness and understanding of his/her situation or feeling.

(5) It directs the client's attention to areas the counsellor thinks need attention.

Components of Probing

The two components of Probing are:

(1) identification, and

(2) open-ended phrasing.

The counsellor uses his/her judgment to identify a subject or feelings area touched on by the client that needs further exploration. As with the other skills practised in this training program, it is important that the counsellor use Probing only after attending to the client. By

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                    │     Purposes of Probing      │
                    │                              │
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HELPS THE CLIENT TO:	ENCOURAGES THE CLIENT TO:	ENABLES THE COUNSELLOR TO:
• Focus his/her attention on a feeling or content area. • Become aware and understand his/her situation or feeling.	• Elaborate, clarify, or illustrate what he/she has been saying. • Focus his/her attention to areas the counsellor thinks need attention.	• Better understand what the client is describing.

listening to and observing the client, the counsellor may identify matters that either seem unresolved or seem to need further development.

In Probing, the counsellor decides what area might need further attention, whereas in Paraphrasing, Reflection of Feeling and Summarizing, the counsellor attempts to feed back to the client in a more concise way the same material or feelings the client presented or displayed.

After identifying the area that needs to be explored further, the counsellor attempts to phrase an open-ended question or statement to include such words as what, where, when or how.

For example, "When do you feel that way?" "Where does that occur for you?" It is generally best to avoid asking questions beginning with the words *are*, *is*, *do*, or *why*. The first three of these words tend to elicit one-word answers. "Why" frequently poses a question that the client cannot answer. As a result, the client may feel defensive and resist further exploration of the topic, or may indulge in vague speculation.

Assessing the Outcome of Probing

As with the other skills studied, how effectively a counsellor has probed can best be determined by the client's response. If the probe encourages the client to talk in greater depth about his/her feelings or the content identified by the counsellor, then the technique has probably been helpful. Similarly, if the probe seems to make the client more aware of a situation he/she has tended to avoid or ignore, and more apt to discuss it specifically, then the probe has been effective. In general the probe may be seen as effective when the client responds by talking further about the subject or feeling at a deeper level (as opposed to a superficial, intellectualizing level).

Sometimes, the counsellor may probe an area that the client is not yet ready to discuss or deal with. In that case, the counsellor might encounter extended silence or some other form of resistance on the part of the client. Or the client may simply say "I'd rather not talk about it." The probe might still be considered effective in this case, because the counsellor may have succeeded in directing the client's attention to a problem area which either the client or the counsellor might come back to later.

Summary of Probing

Probing is the use of a counsellor question or statement to direct the client's attention inward to explore his/her situation in depth. The counsellor identifies an area which seems to need exploration and then phrases an open-ended question or statement. Used effectively, Probing should help both the client and counsellor to better understand the client's situation.

INTERPRETING

Most people place limits on how they will look at problems or situations. As a result of this restricted outlook, people make comments like "I could never do that" when asked why they never considered doing such a thing. This kind of thinking typifies narrow vision, and hinders people from arriving at other ways of looking at problems or situations. People thus become further entrenched in the one position rather than trying to expand their thinking or perspective. The counsellor, as well as the client, is subject to falling into the trap of restricted thinking. After learning the skill of Interpreting, the counsellor will be able to help clients broaden their perspectives. To do so, the counsellor has to broaden his/her own way of viewing problems and situations.

Definition of Interpreting

Interpreting is a technique used by the counsellor to help a client develop and explore alternative ways of looking at a problematic situation. This not only allows the client to view the problem from a different perspective, but implies the development of a new range of coping strategies to deal with the concern.

Helping the client explore different ways of interpreting a problem involves a range of counsellor responses: from stating a new perspective for the client to consider, to asking a probing question which directs the client to provide the alternative viewpoint. For example:

Counsellor: Your behaviour in the past makes you feel embarrassed about the help your father wants to give you now. Is that what you mean? (**REFLECTIVE SKILL – REFLECTION OF FEELING**)

Client: Yeah, I've been in and out of serious trouble for several years, and I'm not sure he should.

Counsellor: Sounds like you're struggling with whether or not you should accept help from him. (**REFLECTIVE SKILL – PARAPHRASING**)

Client: Yeah, I guess maybe I have always had this thing about not owing anything to anyone. But now I don't know – my father really seems to want to help me. I just don't know what to do.

Counsellor: At this point you seem to feel that you don't deserve any help from your father, yet he seems to want to give it. (**SUMMARIZING**).

Have you considered the possibility that maybe he doesn't hold the past against you and really cares about you? (**INTERPRETING – COUNSELLOR PROVIDES THE ALTERNATIVE INTERPRETATION**)

or

Counsellor: At this point you seem to feel that you don't deserve any help from your father, yet he seems to want to give it. (**SUMMARIZING**).

How do you think your father feels about all this? (**INTERPRETING – CLIENT PROVIDES THE SPECIFIC INTERPRETATION AT THE DIRECTION OF THE COUNSELLOR**)

NOTE: The interpretation (directive skill) comprises a reflective response followed by a probing question (see components of Interpreting).

Interpreting differs from the four reflective counselling skills in that it involves the addition of new material (i.e. a perspective) to what the client has said, or explicitly directs the client to generate and consider an alternative viewpoint.

In other words, in Attending, Paraphrasing, Reflection of Feeling and Summarizing, the counsellor attempts to understand, maintain, and reflect the client's frame of reference (thus the title "reflective skills"). In Interpreting, the counsellor offers a new frame of reference to the client. Interpreting, as defined here, is not the "in-depth" type of interpretation that psychoanalysts might do. In this training program, the emphasis in interpretation is not on "digging into the client's psyche" but on exploring alternative points of view in regard to his/her immediate problem or situation.

Purposes of Interpreting

(1)   It helps the client realize that there is more than one way to look at most situations, problems, and solutions.

(2)   It offers the client a role model in seeking alternative ways of viewing events in life (if the counsellor provides the interpretation).

(3)   It can teach the client to become more flexible and to explore new points of view.

(4)   It can help the client understand his/her problems more clearly.

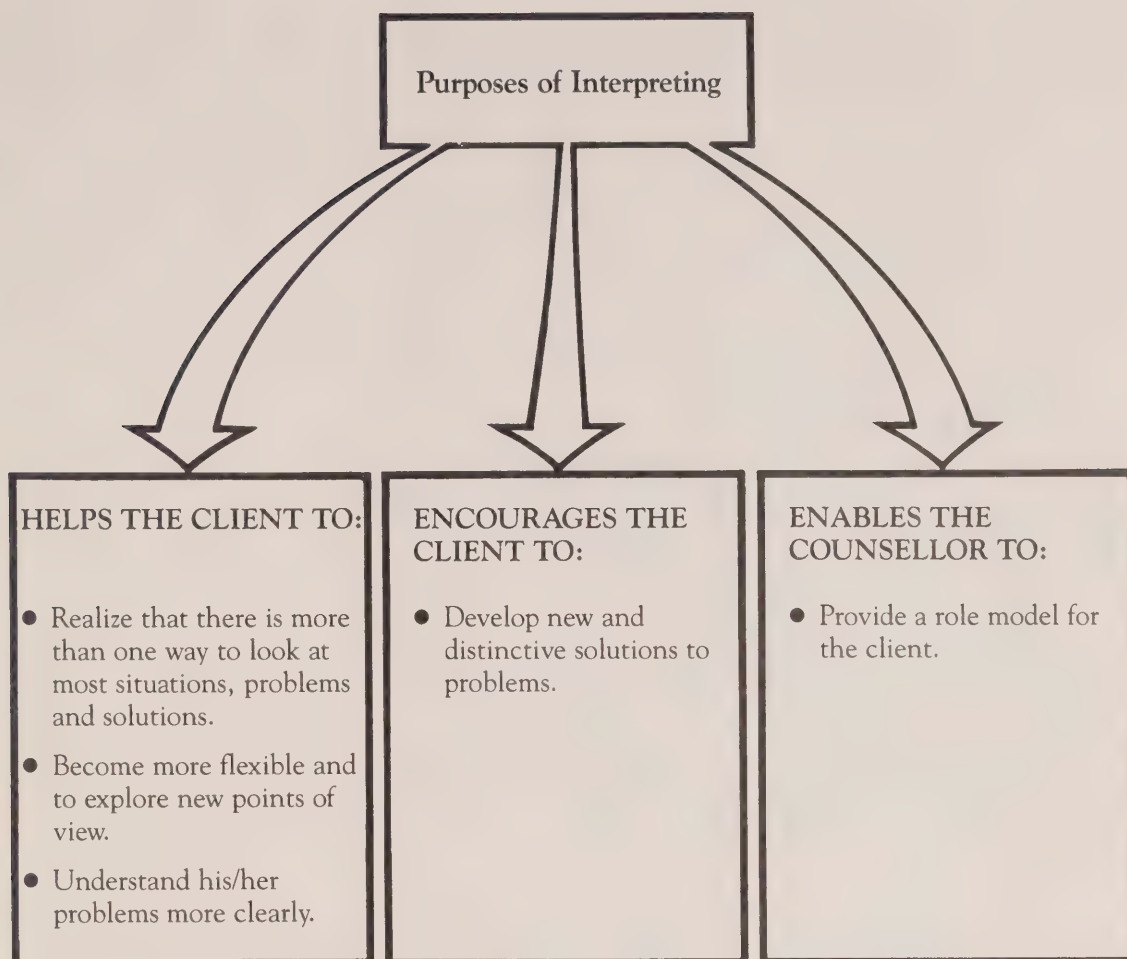(5)   It often helps generate new and distinctive solutions to problems – solutions that are "owned" by the client.

Components of Interpreting

Effective Interpreting has three components:

(1)   determining and restating the basic message;

(2)   adding a new frame of reference, or directing the client to develop a new frame of reference;

(3)   checking out whether or not your "new perspective" has validity for the client. (This may be implicit in the phrasing of the interaction and needn't be a separate statement.)

The basic framework on which all of the counselling skills presented thus far have been built is the ability to listen effectively and observe carefully. It is especially important that the counsellor employ the skills of Attending, Paraphrasing, Reflection of Feeling, and Summarizing prior to and in conjunction with Interpreting. The first step in Interpreting is to determine the basic messages the client has expressed or displayed and restate them. The counsellor seeks to determine the essence of what the client is saying or doing (the client's frame of reference) and then restates this in a paraphrase, reflection of feeling, or summary.

As the counsellor is determining the basic messages and restating them, he/she probably will have some ideas or hunches about alternative ways of viewing the client's situation, or may

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                    │   Purposes of Interpreting   │
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HELPS THE CLIENT TO:	ENCOURAGES THE CLIENT TO:	ENABLES THE COUNSELLOR TO:
• Realize that there is more than one way to look at most situations, problems and solutions.	• Develop new and distinctive solutions to problems.	• Provide a role model for the client.
• Become more flexible and to explore new points of view.		
• Understand his/her problems more clearly.		

begin to see connections, relationships, or patterns in the events the client describes. When these ideas are included in the material being restated to the client, the counsellor is Interpreting.

Because the counsellor is departing from the client's frame of reference and offering alternative viewpoints, it becomes very important to phrase any interpretation tentatively or to check out with the client his/her reaction to any new points of view. Tentative phrases such as "The way I see it …" or "I wonder if …" are appropriate ways to begin an interpretation.

This is very similar, it will be noted, to a Probing question, but it focuses the direction of the client's attention in a more specific manner.

Guidelines for Effective Interpreting

Interpreting is a more complex and subtle skill than others included in this program. Because it can be a potent promoter of behaviour change, however, it is worth the effort required to learn Interpreting and use it effectively. Some general guidelines follow:

(1) The counsellor must distinguish between helping the client explore a new frame of reference and telling the client what to do. Interpreting implies that the client must consider a new way of thinking about a problem, not a new way of solving the problem. Problem solving may be generated by the client.

Telling a client what to do (advice giving, or problem solving for the client) will often result in the client transferring responsibility to the counsellor – responsibility for the solution of the original problem and for the new problems that the counsellor's solutions have generated for the client. When the client is responding with "yes … but …" you are almost undoubtedly advice giving rather than Interpreting.

(2)   In formulating interpretations, the counsellor should use simple language, geared to the level at which the client is operating. An extreme example of not staying at the same level as the client, who wishes his dad would lose some weight, is "You're suffering from typical castration anxiety complicated by Oedipus conflicts." He/she should avoid jumping too far ahead of the client, indulging in speculation, or stating the interpretation in such a way as to seem to be showing off psychological expertise. In addition, the counsellor should avoid labelling clients or using the jargon of psychotherapy.

(3)   The counsellor should encourage clients to get in the habit of considering a range of interpretations or alternative ways of perceiving all of their life situations.

Outcomes Expected from Interpreting

The effectiveness of interpretation can be determined by the client's reaction to any frame of reference offered. If the alternative point of view is close to what the client has expressed, the client might immediately accept the interpretation as a useful way to rethink the problem. In some cases, the client might seem to get a sudden recognition of what the problem is. A response such as "I just realized that's it," could be a typical reply.

If the interpretation varies somewhat from what the client has expressed, several reactions are possible. The client might accept a new frame of reference tentatively: "I'll have to think about that one." On the other hand, the counsellor should be cautious in proceeding in the direction of an interpretation that the client accepts without any hesitation, because it could mean that the client does not feel free to challenge anything the counsellor says. However, if the counsellor keeps in mind the procedure of checking out perceptions with the client, the counsellor's interpreting and subsequent responses will be made tentatively or cautiously.

If the interpretation is too extreme, the client might become anxious or threatened and the session could be disrupted. Or the client again might accept the interpretation at a cautious or tentative level.

Although the client will usually make some sort of response immediately after an interpretation (as opposed to saying nothing), the actual effect of the attempt to offer an alternative point of view may not be realized by either client or counsellor until later. The client may come back to the next session, after having given the new point of view some thought, and indicate that he/she wishes to explore that or other alternatives to the way he/she has been thinking.

Summary of Interpreting

Interpreting is presenting the client with alternative ways of looking at his/her situation. It involves determining and restating the basic messages of the client, directing the client to a new frame of reference, and checking out with the client the acceptability of the new point of view. Used effectively, Interpreting should assist the client to realize that there is more than one way of viewing most situations and help him/her apply this kind of unrestricted thinking to all aspects of his/her life.

CONSTRUCTIVE CONFRONTATION

Constructive confrontation is the process through which the counsellor points out discrepancies that the client is presenting.

Types of Discrepancies

A discrepancy or contradiction in what the client communicates is often a clue to the counsellor that confrontation is indicated. A discrepancy or contradiction might be one of the following general types:

(1)   A discrepancy between how the client sees himself/herself and how others see him/her – for example, the client may describe himself/herself as an outgoing, talkative person, but the counsellor perceives the client as extremely quiet and reserved.

(2)   A contradiction between what the client says and how he/she behaves – for example, the client says he/she is not depressed but he/she is talking slowly, sitting in a slumped posture, looking as if he/she is ready to cry.

(3)   A discrepancy between two statements by the client – for example, a client may say he/she wants to be treated for his/her drinking problem, but later says the only important thing to him/her is saving his/her driver's licence.

(4)   A contradiction between what the client is now saying she believes and how he/she has acted in the past – for example, a client may say he/she has no trouble staying away from the bottle, but he/she has had three slips in a month.

Purposes of Confrontation

(1)   It helps the client become more congruent (what he/she says corresponds with how he/she behaves) when the client sees how he/she is being perceived by the counsellor.

(2)   It establishes the counsellor as a role model in using direct, honest and open communication.

(3)   It tends to focus on problems about which the client might take action or change his/her behaviour.

(4)   It often breaks down unnecessary defences, which the client has consciously or unconsciously put up.

(5)   It tends to enrich the condition of empathy in the counselling relationship when the client perceives the confrontation as being done by a concerned counsellor.

(6)   It encourages the client to acknowledge his/her feelings and behaviour by bringing to the surface those he/she may have denied or overlooked. Once the client has accepted ownership of these feelings and behaviours, he/she is more likely to accept responsibility for them.

(7)   Confrontation must only be used for the client's benefit in the counselling process. It is not an escape valve for the counsellor's frustration in working with a difficult client. If the counsellor is not absolutely certain that the confrontation is in the best interest of the client, then it should be avoided. The purpose of confrontation is to aid and strengthen the counselling process in a positive, constructive fashion.

Using Confrontation Effectively

There are a few guidelines that the counsellor should keep in mind when formulating a confrontive response. First, and perhaps most important, mutual trust and empathy must already be firmly established as part of the counselling relationship. Confrontation should come across as a positive and constructive act by a caring counsellor, not as a negative and punitive act of a judgmental counsellor. This attitude of empathy and caring can be transmitted not only by what the counsellor says but also by his/her tone of voice and facial expressions when the confrontation skill is used.

The counsellor should also keep in mind that the most effective responses are those that address specific, concrete attributes of the client's behaviour that the client can do something to change. It isn't very helpful to confront general behaviour: for example, "You're always talking about changing your behaviour, so why don't you do it?" An example of a specific confrontation would be, "You say you want to quit drinking, but what I see you doing is figuring out how to get a pint to get through the day." The counsellor must always present specific evidence of the discrepancy.

Confrontation may be directed toward the client's assets (strengths) or his/her limitations (weaknesses). The counsellor should be wary of always identifying contradictions that point up weaknesses in the client. Confrontive skills can be used constructively by focusing on strengths of the client. For example, to the client who expresses lack of confidence in his ability to handle stressful situations without drinking, the counsellor might say, "Although you say that you can't handle this, the last time this happened you called me and did most of the work of sorting things out and deciding what to do."

In practical application, the confrontation response often takes the form of a compound statement that sets up a "you say ..., but you do ..." format. The second part of the statement points out the discrepancy or contradiction in the client's behaviour or message. For example, "You say you don't want to see him again, but you go to places where you know he'll be." Another useful expression of this format is: "On one hand A ... and on the other hand B ... How does this fit for you?" In using confrontation, then, the counsellor listens to the client's feelings and content messages, observes the client's behaviour, and presents evidence of a contradiction or discrepancy to the client, if it appears helpful to do so.

Because confrontation is an extremely powerful tool for the counsellor to use, here are certain risks involved. Whenever the counsellor becomes aware of a discrepancy or contradiction in the client's behaviour or messages, the benefits of using confrontation must be weighed against the risks.

If trust and empathy have not been firmly established in the counselling relationship, the premature use of the skill of Confrontation could harm the relationship. The client could become distrustful of the counsellor or decide that the counsellor cannot be of any help to him/her. The use of confrontation can be very threatening and anxiety producing for the client, and if the proper conditions aren't there to begin with, it can damage or end the counselling relationship.

The use of confrontation may precipitate a crisis in the client's life. Especially if a client seems emotionally unstable about certain areas of his/her life, it might not be wise to confront him/her on those particular areas. For example, if a client has just been fired from his job and is very upset about it, the counsellor should probably not confront him at the moment with his job performance.

Sometimes, on the other hand, the counsellor does not confront the client because the counsellor is protecting himself/herself from risk. The counsellor might not like to deal with the extreme emotional reactions that could follow a confrontation, or may not be comfortable with anger, anxiety or tears. The counsellor may pass over an appropriate confrontation situation because he/she would be uncomfortable if the usual defences were dropped and thus wants to prevent the relationship from getting too close or intense. Thus, the counsellor

should not only be careful to use appropriate reasons and timing for confrontation, but should also take care not to avoid it.

In deciding whether to confront or not, the counsellor must weigh the possible benefits to the client against the possible harm. In addition, if the counsellor is hesitating to confront, he/she should ask himself/herself whether this reluctance is out of concern for the client or out of self-concern. If the counsellor recognizes that the reluctance to confront is out of concern for himself/herself, the counsellor should search himself/herself to see whether the cause of the apprehension is a legitimate concern, such as fear of physical harm from an intoxicated client, or whether it is a fear the counsellor should try to resolve with himself/herself.

The Outcomes of Confrontation

If the counsellor's confrontation has been effective, it could lead to exploration of previously blocked or denied feelings or behaviour. In addition, an effective confrontation can often bring about a kind of breakthrough in the client's recognition that a behaviour change is needed.

In practice, the counsellor often may not know whether the confrontation has been effective or helpful until after several more exchanges in the session or until a later session. The client's immediate response to the confrontation sometimes does not indicate its effectiveness.

Frequently, the beginning counsellor does not know what to do after he/she attempts to use the skill of confrontation. The following general guides might help:

(1) If the client accepts the confrontation and agrees with the discrepancy pointed out, the counsellor can use the opportunity to reinforce positive behaviour. The counsellor might say, "It's really a step in the right direction that you can recognize and accept this contradictory behaviour so easily."

(2) If the client denies the confrontation, the counsellor (who may be wrong) is probably wisest to return to an empathic response. The client may not be ready to deal with the discrepancy at that time and it would not be helpful to persist in the confrontation. "Think about this as homework and we will return to this idea next week (or later in the session)."

(3) The client may simply act confused or ambivalent after a confrontational statement. In that case, the counsellor could focus on the current feeling by saying, "You seem to feel confused by my saying that."

Summary of Confrontation

Confrontation is a process whereby the counsellor points out discrepancies that the client is presenting. A constructive Confrontation response by a counsellor is composed of two discrepant messages received by the counsellor and followed by a Probing question: e.g.

"At the beginning of the session you said you hadn't had a drink in two months, but on the other hand you just said you had a "slip" last weekend. I'm a little confused; how does that fit, Sam?"

When using the skill of confrontation, the counsellor must present "evidence" of the contradiction and must be specific rather than general or vague. This is not a skill to be overused – a little confrontation can go a long way.

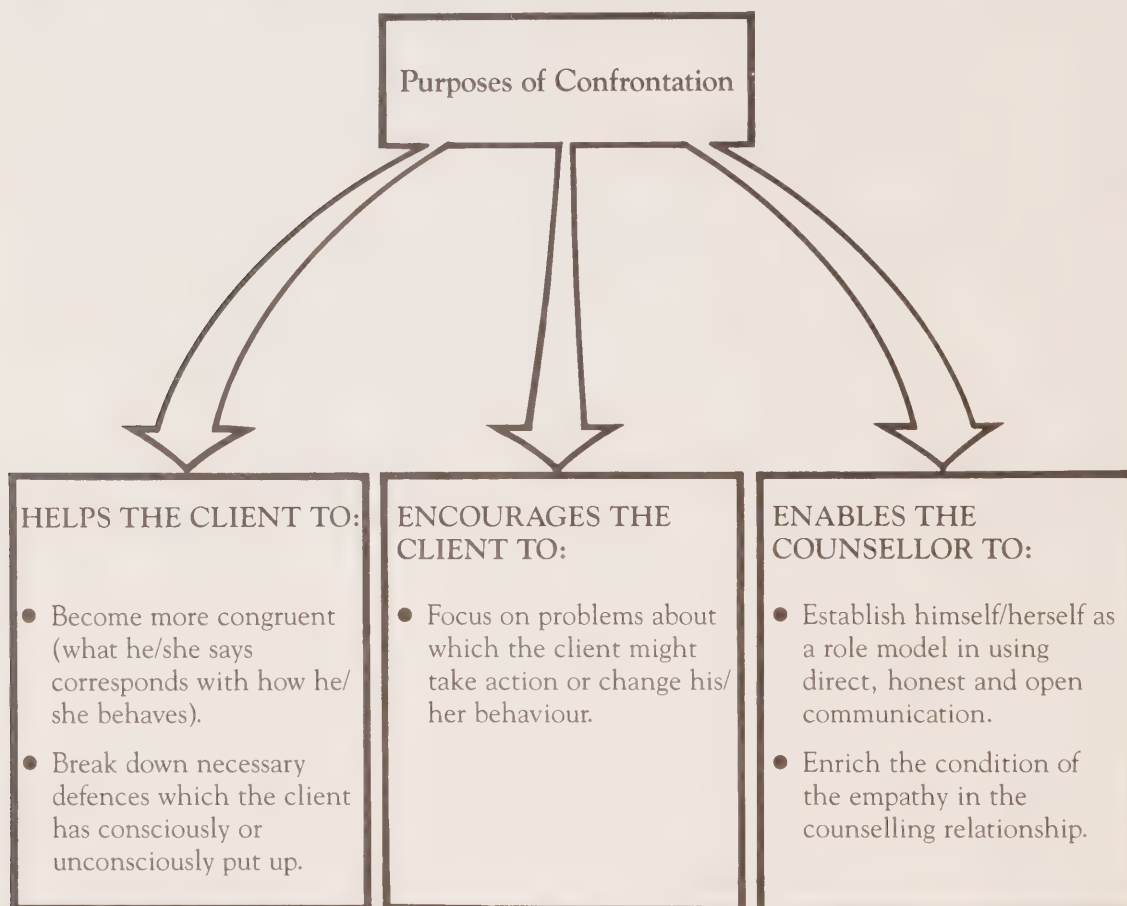**In summary**, the three directive counselling skills are:

(1) *Probing* – a counsellor response phrased as an open-ended question which directs the client to explore a specific subject at greater length;

(2) *Interpretation* – a counsellor response directed at helping the client explore an alternative perspective on a problematic issue.

(3) *Constructive Confrontation* – a counsellor response which illustrates apparent discrepancies that a client is presenting.
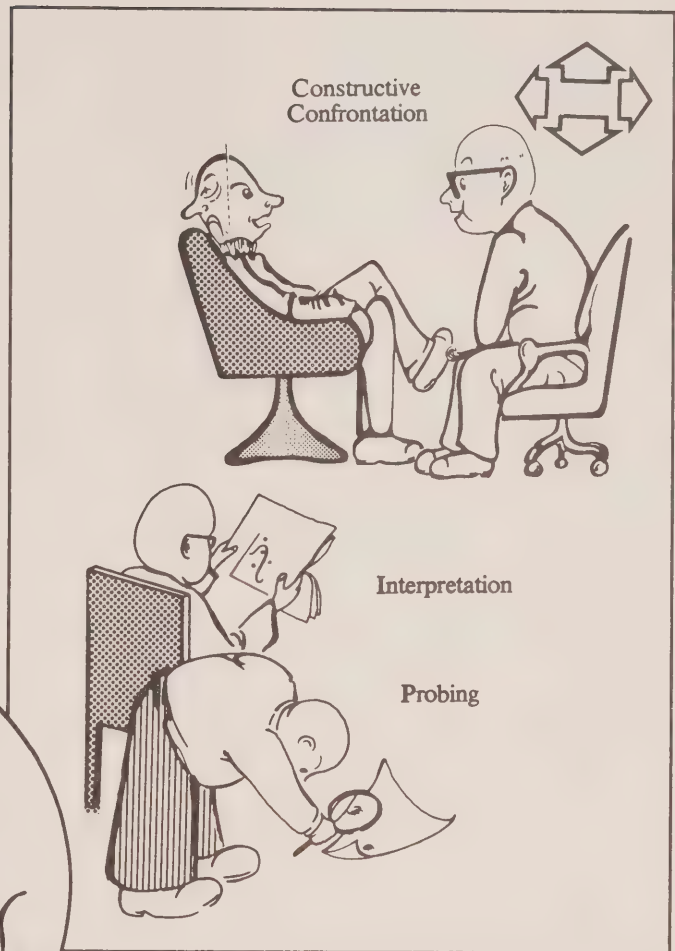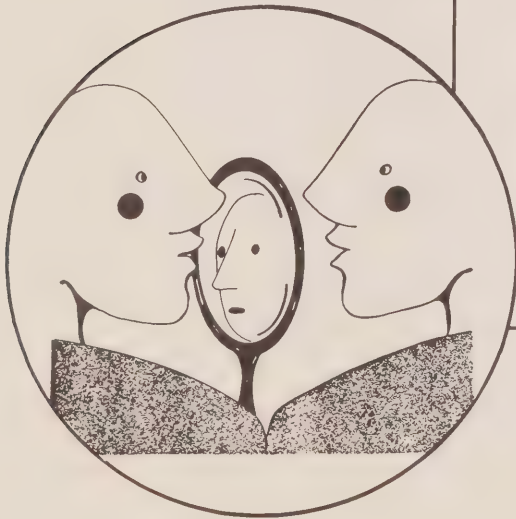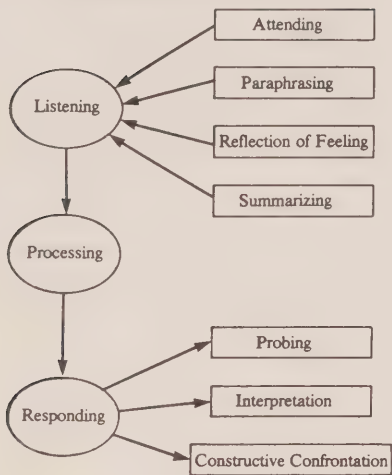
Exercise

Now that you have completed reading the material for both directive and reflective counselling skills, it is time to test your knowledge of this material.

In the blank space provided after each counsellor response below, correctly identify the skill that the counsellor is using. The answers are provided in Appendix C. If you make any errors, please re-read the section in your manual which refers to the skill that you were not able to identify. If you still have questions after re-reading the material, be sure to clarify them with the instructor when you review the skill in question.

Purposes of Confrontation

HELPS THE CLIENT TO:

• Become more congruent (what he/she says corresponds with how he/she behaves).

• Break down necessary defences which the client has consciously or unconsciously put up.

ENCOURAGES THE CLIENT TO:

• Focus on problems about which the client might take action or change his/her behaviour.

ENABLES THE COUNSELLOR TO:

• Establish himself/herself as a role model in using direct, honest and open communication.

• Enrich the condition of the empathy in the counselling relationship.

Module 4: OBSERVATIONS AND CONCLUSIONS

EXPLAIN THE CONCEPTS:

- Attending
- Paraphrasing
- Reflection of Feeling
- Summarizing

Listening → Processing → Responding

- Probing
- Interpretation
- Constructive Confrontation

Constructive Confrontation

Interpretation

Probing

PRACTICE EXERCISE – REFLECTIVE AND DIRECTIVE
COUNSELLING SKILLS

Client: I'm so upset this morning that I can't even think. You just wouldn't believe what my father has done.

Counsellor: Could you tell me a little more about it?

Client: Well, you know my mother just died a few months ago, poor little thing, she was so afraid of dying, and she was sick for so long. We all did everything that we could for her and I thought Daddy loved her and cherished her memory. It was just awful. I had a telephone call from this friend of mine last night and she said, "Do you know where I saw your daddy last night?" He was at a bar with this woman – I know her and I can't wait to get back to her and tell her what I think of her.

Counsellor: You seem to feel pretty displeased with your dad's behaviour.

Client: I sure am. I mean the flowers haven't even wilted on Mother's grave and he's out catting around. We moved in to help take care of him – but I'm moving out tomorrow. I told him so. He came in this morning looking like a sheepdog and I really let him have it.

Counsellor: You moved in to take care of your dad, but have you considered that maybe he's lonely and needs some companionship after losing your mother?

Client: Well, that may be, but that doesn't explain why he wasn't all that good to Mother while she was alive. He used to play poker, or so he said. I'm not sure what he was doing. But Mama would call me and – I didn't have a car because George was always gone to some beer joint in it – but poor Mama would cry and say how lonely she was and I know she was sick and afraid and there was nothing I could do.

Counsellor: So you were dealing with two problems – your mother's poor health and loneliness and your husband's drinking?

Client: Yeah, but Mama's sickness bothered me more than George's carousing and drinking. You know, when Mother was in the hospital this last time Dad never left her – it just doesn't fit together for him to act like this. There was never a better woman than my Mother – he could at least have waited.

Counsellor: Sounds like you loved and admired your mother a great deal.

Client: I did. She was so good to me and I felt so horrible and helpless when she died. I just feel like I've got all these responsibilities now and I don't know if I can handle them. That's why I get so mad when I think my Dad isn't helping me.

Counsellor: You feel weighted down by many problems and resentful that no one is helping you face them, is that it?

Client: Yeah, I do. I mean there's my little brother still at home, and he's in jail for drunk driving and where's that going to leave him with no mother, and a daddy who runs around and drinks and lets him have all the money he wants and the car and a credit card. And then he keeps saying he doesn't know what to do with the boy. Mama would turn over in her grave if she knew he was in jail. And

| | George has that drunk driving charge against him from the accident, and you know he's out of work. I just don't know if I can keep going on. |

Counsellor: At this point, it looks like you're going through a lot emotionally. You're feeling hurt about your mother's death, frustrated about your husband's drinking, discouraged about your brother's actions, and angry at your dad's behaviour.

Client: Yeah, that about covers it, but I left out how mad I am at that woman. She knows how we all feel about her – when I get through with her she won't know what hit her. The others, they won't do anything, but I will. I may be the youngest, but I can hang in there whenever I get mad, and I was so mad. I really gave Dad a tongue lashing I'll never forget and he won't either. I told him I was ashamed of him and I'd never forgive him and he could just find someone else to wash his clothes and fix his meals.

Counsellor: You know, so far you have told me how upset you are about your mother's death and how angry you are at your father; how do you think your father feels about your mother's dying?

Client: Well … I guess it really hurt; just to sit and watch her dying and not being able to do anything about it. Yeah – it really did hurt, he cried when Mama got so bad that she couldn't get out of bed. He said he couldn't stand to see her that way, he was really broken up after that … (pause) … I guess that could make you do some pretty crazy things, eh?

Counsellor: Well, what do you think?

Client: Yeah, I guess it's made me do some pretty crazy things … What do you think I should do?

Counsellor: Well, on the one hand, you seem to be condemning your father as the culprit, but on the other hand you are saying that, with all this stress, you have done some pretty crazy things too.

Client: Yeah, I see what you mean – I guess one of my crazy things was all the yelling, eh?

Counsellor: Perhaps, but let's go back to how your father might feel for a minute longer – OK? You said earlier that you were angry because you felt that your Dad wasn't helping you. How do you think your Dad feels about how you have helped him since your Mom died?

Client: Well … I moved in to help him and I know he appreciated it, but then he took off with this other woman … (pause) … I guess my shouting and yelling and creating a fuss didn't help Dad or me – he was really upset – he didn't even say anything, just sort of stood there looking pathetic. I'm so confused … (pause) … I really hate that woman!

Counsellor: Can you tell me more about your hate?

Client: Well, Daddy isn't the first man she's gone after, you know. She tried to pick up George once.

Counsellor: Ah.

Client: I mean he wouldn't have anything to do with her, but she tried and she's just not above anything. She even called the house once. This whole thing is her fault!

APPENDIX A

FEEDBACK AND ASSUMPTIONS

Feedback

During skill practice sessions, you will take turns as counsellor, client and observer. The client and observers will give the counsellor feedback dealing with his or her performance of the skill in question.

The definition of feedback as used in the context of the practice sessions is: telling the counsellor what you (as observer) heard and saw as he/she practised a particular skill, or what you (as client) felt in response to his/her practice of the skill.

The extent to which you give each other feedback and the quality of the feedback may be the critical factor in determining whether or not this training will be productive for you. For example, if in practice sessions neither the observers nor the clients give you significant feedback about your performance as a counsellor, you might complete your training, having gone through all the prescribed activities, and have gained little. You may perhaps even take away a more distorted rather than a clearer picture of your capabilities. In addition, being a recipient of feedback can help sharpen your perception of what constitutes useful feedback.

When giving feedback, whether positive or negative, keep these guidelines in mind. They apply to both counselling and skill practice situations.

- The purpose of feedback is to be helpful to other people by giving them useful information about what they are doing or the effect they are having on you.

- Timing is important. If feedback is given so long after a happening that the recipient can't remember the happening clearly, it is not likely to be helpful. Feedback is most helpful when given as soon as possible.

- Be specific rather than general. Generalities often raise people's defences so that they don't get the message you are trying to give. It's much easier to hear and acknowledge "I felt annoyed when you were late for our appointment today," than it is to hear and acknowledge "You're always late and I'm sick and tired of it." (Even if the other person is always late and you are sick and tired of it, it's more constructive to deal with specific situations as soon as possible, rather than not give feedback and sit on your feelings until you finally explode).

- Being descriptive rather than judgmental is also less likely to raise people's defences and is more helpful. "You just went through a stop light and you're driving at 40 mph in a 20 mph school zone, and I feel nervous," is more constructive than "You're really a lousy driver".

- The last point to remember about feedback is that it should be directed toward behaviour about which the receiver can do something. While you may find you simply have to tell someone the effect that his/her height, or age, or colour of eyes has on you, this is not feedback. In effect, you're not telling that person anything about himself/herself but something about yourself. Even if it's positive, such as "Darling, I just love your green eyes," you're talking about your own likes or dislikes rather than something someone else has control over and could change if he/she wanted to.

Assumptions

Despite earnest intentions to give accurate and meaningful feedback, we may sometimes unconsciously erect barriers to doing so. These barriers may derive from our own needs, beliefs, prejudices, preferences, values, or fears, and they may frequently take the form of assumptions about others. Sometimes our assumptions are on target; quite often they are far from reality. However, they are accurate often enough to encourage us to keep making assumptions.

Making assumptions often takes the form of taking observable facts about another person, developing a theory to explain those facts, and then treating the other person as if your theory is proven. In alcoholism counselling, this process might mean observing that a client's eyes are bloodshot, assuming that he/she has been drinking, and reacting to the client with anger and disappointment on the basis of your assumptions. The client, however, may actually have hay fever or may not have been able to sleep. This kind of assuming is sometimes called pigeon-holing or stereotyping.

Making assumptions can also take the form of making another person responsible for our feelings. For example, I may feel frightened; if I assume that some other person is threatening to me, then this assumption justifies or rationalizes my fear. This process could easily take place with a client who may, in reality, be dangerous only to himself/herself or not dangerous at all.

Three things to remember about assumptions are:

- **Recognize** that you probably have some.

- **Don't take them too seriously.** You can't know another person's experience, only your own perceptions of that experience. Any conclusions or theories that you may have about another may be accurate or they may be only your assumptions. Suspend judgment about the meaning of your observations until you verify the facts (below).

- **Check them out.** Using nonjudgmental words and tentative phrases, share your assumptions with the recipient and see whether they are accurate or not (e.g. "It seems like you may have been drinking today.") Remember, the object in counselling another is not for the counsellor to be right (and the client wrong) but rather to establish communication, build a relationship, and help the client develop the capacity to deal more effectively with his/her life.

False assumptions are usually rooted in negative (unconstructive) attitudes, which will be further discussed in Unit III, regarding the initial interview.

APPENDIX B

COUNSELLOR RESPONSE-RECORDING FORMS

Opposite each number below, please "label" each skill that the counsellor is using on the videotape, using the terminology of this program.

1,

2,

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PRACTICE EXERCISE – REFLECTIVE AND DIRECTIVE
COUNSELLING SKILLS

Client: I'm so upset this morning that I can't even think. You just wouldn't believe what my father has done.

Counsellor: Could you tell me a little more about it? **(PROBING)**

Client: Well, you know my mother just died a few months ago, poor little thing, she was so afraid of dying, and she was sick for so long. We all did everything that we could for her and I thought Daddy loved her and cherished her memory. It was just awful. I had a telephone call from this friend of mine last night and she said, "Do you know where I saw your daddy last night?" He was at a bar with this woman – I know her and I can't wait to get back to her and tell her what I think of her.

Counsellor: You seem to feel pretty displeased with your dad's behaviour. **(REFLECTION OF FEELING)**

Client: I sure am. I mean the flowers haven't even wilted on Mother's grave and he's out catting around. We moved in to help take care of him – but I'm moving out tomorrow. I told him so. He came in this morning looking like a sheepdog and I really let him have it.

Counsellor: You moved in to take care of your dad, but have you considered that maybe he's lonely and needs some companionship after losing your mother. **(INTERPRETING – COUNSELLOR PROVIDES INTERPRETATION)**

Client: Well, that may be, but that doesn't explain why he wasn't all that good to mother while she was alive. He used to play poker, or so he said. I'm not sure what he was doing. But Mama would call me and – I didn't have a car because George was always gone to some beer joint in it – and Mama would cry and say how lonely she was and I know she was sick and afraid and there was nothing I could do.

Counsellor: So you were dealing with two problems – your mother's poor health and loneliness and your husband's drinking? **(PARAPHRASING)**

Client: Yeah, but Mama's sickness bothered me more than George's carousing and drinking. You know, when Mother was in the hospital this last time, Dad never left her – it just doesn't fit together for him to act like this. There was never a better woman than my Mother – he could at least have waited.

Counsellor: Sounds like you loved and admired your mother a great deal. **(REFLECTION OF FEELING)**

Client: I did. She was so good to me and I felt so horrible and helpless when she died. I just feel like I've got all these responsibilities now and I don't know if I can handle them. That's why I get so mad when I think my Dad isn't helping me.

Counsellor: You feel weighted down by many problems and resentful that no one is helping you face them, is that it? **(REFLECTION OF FEELING)**

Client: Yeah, I do. I mean there's my little brother still at home, and he's in jail for drunk driving and where's that going to leave him with no mother, and a daddy who runs around and drinks and lets him have all the money he wants and the

car and a credit card. And then he keeps saying he doesn't know what to do with the boy. Mama would turn over in her grave if she knew he was in jail. And George has that drunk driving charge against him from the accident, and you know he's out of work. I just don't know if I can keep going on.

Counsellor: At this point, it looks like you're going through a lot emotionally. You're feeling hurt about your mother's death, frustrated about your husband's drinking, discouraged about your brother's actions, and angry at your dad's behaviour. **(SUMMARIZING)**

Client: Yeah, that about covers it, but I left out how mad I am at that woman. She knows how we all feel about her – when I get through with her she won't know what hit her. The others, they won't do anything, but I will. I may be the youngest, but I can hang in there whenever I get mad, and I was so mad. I really gave Dad a tongue lashing I'll never forget and he won't either. I told him I was ashamed of him and I'd never forgive him and he could just find someone else to wash his clothes and fix his meals.

Counsellor: You know, so far you have told me how upset you are about your mother's death and how angry you are at your father; how do you think your father feels about your mother's dying? **(INTERPRETATION – COUNSELLOR DIRECTS CLIENT TO GENERATE THE INTERPRETATION)**

Client: Well … I guess it really hurt; just to sit and watch her dying and not being able to do anything about it. Yeah – it really did hurt, he cried when Mama got so bad that she couldn't get out of bed. He said he couldn't stand to see her that way, he was really broken up after that … (pause) … I guess that could make you do some pretty crazy things, eh?

Counsellor: Well, what do you think? **(PROBING)**

Client: Yeah, I guess it's made me do some pretty crazy things … What do you think I should do?

Counsellor: Well, on the one hand, you seem to be condemning your father as the culprit, but on the other hand you are saying that, with all this stress, you have done some pretty crazy things too. **(CONSTRUCTIVE CONFRONTATION)**

Client: Yeah, I see what you mean – I guess one of my crazy things was all the yelling, eh?

Counsellor: Perhaps, but let's go back to how your father might feel for a minute longer – OK? You said earlier that you were angry because you felt that your Dad wasn't helping you. How do you think your Dad feels about how you have helped him since your Mom died? **(INTERPRETING – COUNSELLOR DIRECTS CLIENT TO PROVIDE INTERPRETATION)**

Client: Well … I moved in to help him and I know he appreciated it, but then he took off with this other woman … (pause) … I guess my shouting and yelling and creating a fuss didn't help Dad or me – he was really upset – he didn't even say anything, just sort of stood there looking pathetic. I'm so confused … (pause) … I really hate that woman!

Counsellor: Can you tell me more about your hate? **(PROBING)**

Client: Well, Daddy isn't the first man she's gone after, you know. She tried to pick up George once.

Counsellor: Ah. **(ATTENDING)**

Client: I mean he wouldn't have anything to do with her, but she tried and she's just not above anything. She even called the house once. This whole thing is her fault!

Module 4: CONTINUED CARE/MANAGEMENT
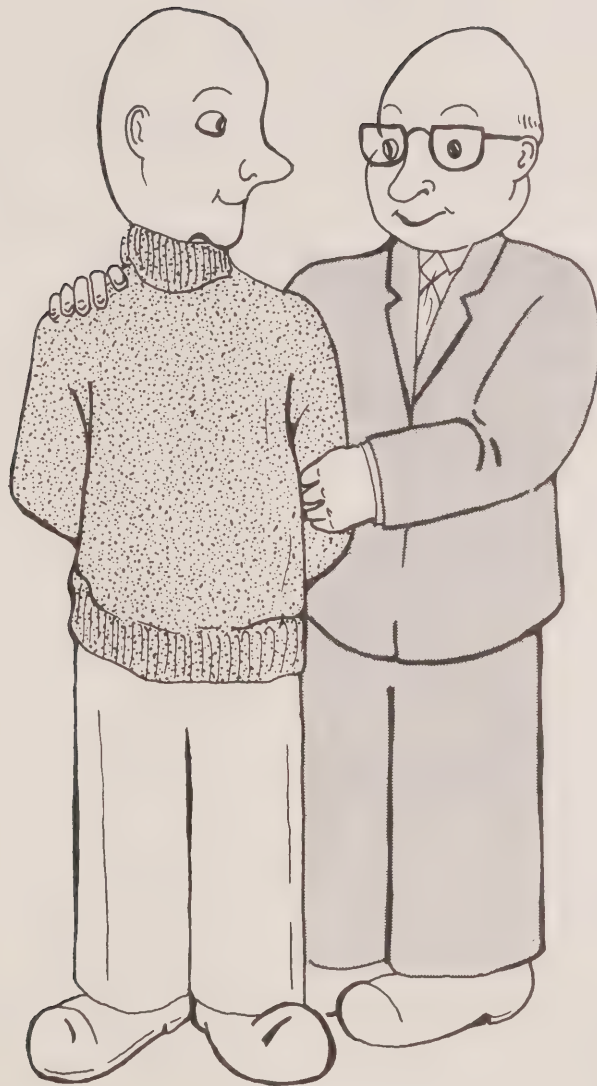
2. **Relapse Response** been planned?
    2.1 Has client practised relapse in simulated situations?
    2.2 Have family/friends been prepared as to how to react?
    2.3 Has client's perception of relapse been restructured to avoid "the abstinence violation effect"?
    2.4 Does the client have someone to call when relapse occurs?
    2.5 Does the client have list of services to contact?

FORMULATING MOTIVATIONAL AND NEGOTIATION RESPONSES: EXAMPLES

(some words you can use)

Motivational Strategies and Skills (Zweben, 1984)

(1) *Engaging responses* include those described as "reflective skills" in Unit I: Counselling Communication Skills:

-    "What I hear you saying is … " (Paraphrasing)

-    "Is that right?" (Checking out)

-    "What we have discussed so far is …" (Summarizing)

-    "You're feeling …" (Reflection of feeling)

-    "What is that like?" (Probing)

-    "You say you're a failure, but over the past five years you have accomplished …" (Constructive Confrontation)

-    "Another way of looking at the situation is …" (Alternative Interpretation)

(2) *Eliciting self-motivational statements* involves asking particular kinds of probing questions. For example:

-    "What problems would you like to solve?"

-    "What would you like to change?"

(3) *Presentation of alternatives* other than continuing drug misuse is verbally describing other ways of achieving what drug misuse achieves. For example:

-    "If that is what you like … also produces that effect".

(4) *Delayed Compliance* involves encouraging the client (paradoxically) to not act, or change too soon. For example, "You may want to make a decision, or change right away but perhaps you should think about it for a while".

(5) *Role Induction* involves clarifying what a client can expect in treatment. For example: "Should you decide to go to … for treatment, this is what you can expect …"

(6) *Immunization* against discouragement involves preparing clients for setbacks by describing what obstacles they might encounter. For example: "You can expect to have some setbacks/second thoughts, such as …" (emphasizing that these need only be temporary).

(7) *Reinforcement sampling* involves deciding together with the client on some new (alternative to drug use) activities and having the client try them. For example: "So we agree that you will try … to see if it helps you …"

Negotiation Principles (Fisher and Ury, 1981)

(1) *Separate the people from the problem* relates to the fact that one can be tough on problems (which are generalizable), but it is important to be soft on people (who are all different and need encouragement). For example: "Continuing to use drugs as you have been will probably result in ... But stopping is difficult for you because of ..."

(2) *Focus on interests* rather than on positions involves the identification of common areas of agreement, instead of dwelling on areas of disagreement. For example: "We agree on the principle that the children need to be protected from ..."

(3) *Inventing options for mutual gain* involves creative problem-solving to generate goals or solutions which serve two opposing side's interests. For example: "If you want to feel good and still have a safe home for your children ... will provide both".

(4) *Using objective criteria* for achieving goals lends confidence to the process. For example: "We will know when we have achieved ... when ... happens".

FIGURE 13

NEGOTIATION CHECKLIST FOR DRUG MISUSE
TREATMENT AND PREVENTION

Have

		Yes	No
1.	*Attitudes* (values, intentions, beliefs) been constructive?	___	___
	1.1 Aware of attitudes?	___	___
	1.2 Suspended judgment?	___	___
	1.3 Checked out correctness of assumptions?	___	___
2.	*Motivational Principles* been used?	___	___
	2.1 To de-emphasize labels?	___	___
	2.2 To emphasize client's responsibility?	___	___
	2.3 To attribute control to being internal?	___	___
	2.4 To identify cognitive dissonance?	___	___
3.	*Motivational Guidelines* been used?	___	___
	3.1 To increase self-esteem?	___	___
	3.2 To increase efficacy?	___	___
	3.3 To increase cognitive dissonance?	___	___
	3.4 To direct cognitive dissonance?	___	___
4.	*Motivational Strategies* been used?	___	___
	4.1 Reflective (listening) Skills used?	___	___
	4.2 Directive (responding) Skills used?	___	___
	4.3 Self-motivational statements elicited?	___	___
	4.4 Alternatives presented?	___	___
	4.5 Delayed compliance used?	___	___
	4.6 Treatment role induction used?	___	___
	4.7 Immunization against discouragement used?	___	___
	4.8 Reinforcement sampling used?	___	___
5.	*Negotiation Principles* been used?	___	___
	5.1 People been separated from the problem?	___	___
	5.2 Interests been focused on rather than positions?	___	___

	Yes	No
5.3 Options for mutual gain been invented?	____	____
5.4 Objective criteria been established for successful agreements?	____	____
5.5 Previous attempts been described and taken into account?	____	____
6. *Decisions* been negotiated about drug-related problems?	____	____
6.1 Does client acknowledge problem?	____	____
6.2 Does client want to change problem?	____	____
6.3 Has a plan been designed?	____	____
6.4 Has provision been made to evaluate the plan?	____	____
6.5 Have criteria for success been agreed to?	____	____
6.6 Has a follow-up plan been designed?	____	____
6.7 Has a relapse prevention and response plan been agreed to?	____	____
7. *Drug Dependence Issues* been considered? (regarding the client)	____	____
7.1 Loss of highly valued experience knowledge?	____	____
7.2 Perceived helpless been examined?	____	____
7.3 Conflicting theories been discussed?	____	____
8. *Drug Dependence* Issues been considered? (regarding the counsellor)	____	____
8.1 Values congruent with client's needs?	____	____
8.2 Beliefs based on correct information?	____	____
8.3 Negative feelings under control?	____	____
8.4 Feel competent to counsel in this area?	____	____
8.5 Recognize multiple causation?	____	____
8.6 Recognize importance of early detection?	____	____

FIGURE 14

THE DEPENDENCY CHECKLIST

Instructions

For each act that applies to you, put the number of as many reasons as seem appropriate next to the act. Try to remember your initial reasons (and include these) for doing the act, as well as your current reason(s). Even if some acts don't apply, you may fill in reasons if you can imagine yourself doing the act.

Feel free to add items to either side of the list.

When you have completed the checklist, circle three or four items that have at least six reasons assigned to them.

THE DEPENDENCY CHECKLIST

ACT

Smoking

Drinking coffee/tea

Having a drink

Watching a particular TV show

Playing a musical instrument

Making love

Eating pastry on Sunday morning

Walking the dog

Going to religious services

Playing a sport

Sunbathing

Cooking dinner

Not being a parent

Taking a tranquillizer

Taking vitamins

Buying a house

Having a savings account

Paying each bill the day it comes in

Not being late

Buying clothes

Grocery shopping

Reading a book

Having a routine

Having a place for everything

REASONS

1. Makes me feel good.

2. Reduces tension.

3. Puts order in my life.

4. Gives me something that is uniquely mine.

5. Perks me up.

6. Calms me down.

7. Provides a change of pace.

8. Gives me social acceptance.

9. Gives me a sense of well-being.

10. Makes me anxious if I don't do it.

11. Makes me feel guilty if I don't do it.

12. Makes me feel "square" if I don't do it.

13. Makes me feel in control of my life.

14. Usually I just have to do it – it is one of life's givens.

INITIAL
INTERVIEW METHODS

TABLE OF CONTENTS

INTRODUCTION

Effective *interviewing* for assessment, for referral, and/or for treatment planning requires more than interpersonal skills and specialized knowledge. The counsellor also needs to understand and practise effective interview methods. Forms for gathering and organizing a wide variety of client information are often required administratively, and counsellors often find these to be difficult to integrate into interviews.

This Unit builds on the combination of counselling communication skills and practical drug concepts to describe and practise methods of conducting initial interviews. The focus is on: how to get started; how to explain, and how to conduct structured and other forms of assessment interviews.

Module 1: ASSESSMENT

Specialized

Comprehensive

Brief

ASSESSMENT: Explain the relevance of assessment
to the counselling process

DISTINGUISH: Level of assessment

Module 1: ASSESSMENT

Introduction

This Unit is intended to train addiction counsellors to more fully understand the value and relevance of assessment interviewing; to increase participant knowledge and skills in the conduct of an initial interview, and to provide a framework for the organization and recording of information collected in the assessment process. This Unit will provide the opportunity for the integration of basic counselling/communication skills, practical drug concepts, and assessment processes. We are familiar with this program's interpretation of the terms "counselling/communication skills" and "practical drug concepts", so we begin with a simple definition of ASSESSMENT.

Assessment involves the use of systematic procedures for the identification of a person's major strengths and problem areas.

Since everyone is an individual, and because there are varying degrees of involvement with alcohol[1] (ranging from people moderately at risk to reasonably heavy drinkers, to chronic alcoholics), assessment should:

(a)   evaluate the specific nature and extent of a given individual's problems (and areas of strength and support);

(b)   order problems with respect to their urgency;

(c)   determine the most appropriate interventions;

In the *process* of conducting the assessment an additional fourth element must be added; hence, in the initial interview, the assessment process should also (in addition to a, b, and c):

(d)   develop rapport with the client in order to establish a healthy working relationship.

During the initial interview, then, the interviewer has two major roles:

(a)   to establish rapport; and

(b)   to gather information.

The ultimate goal of the assessment process is to make the best possible match between the needs of the client and the treatment resources available.

Although we began with a simple definition, the assessment process is a complex entity. One dimension of this complexity involves different *levels of assessment*. For example, with a relatively few simple questions you can discern whether a person appears to be quite "normal", or whether he/she might be able to use some kind of help. This first level of assessment is called **BRIEF SCREENING** (see examples 2, 3, and 4, pages to). The function of a brief screening interview with respect to the assessment of alcohol problems is to provide the interviewer with enough information to make a decision as to whether or not to proceed with (or in some instances to refer the person onward for) a **BASIC COMPREHENSIVE ASSESSMENT**. The primary function of this next level of assessment is to provide the assessor with enough information to develop a comprehensive treatment plan with the client and then:

(a)   implement this treatment plan by conducting some or all of the treatment, or

(b)   refer the client to the most appropriate treatment resource for the presenting problems.

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[1]Note that the terms alcohol and drug may be used interchangeably throughout this program.

Aside from referral for treatment, this second option may involve referral for the third level of assessment – **SPECIALIZED ASSESSMENT**. This level could include psychiatric examination, psychological testing, and other highly specialized and acutely focused assessment procedures. The core of this Unit will stress the intermediate level of assessment – that of **BASIC COMPREHENSIVE ASSESSMENT**.

Another level of complexity in the assessment process involves the "type" or "style" of assessment. Two of the most common types or styles of assessment are:

(a)   the *PSYCHOSOCIAL INTERVIEW*, and

(b)   the *STANDARDIZED INTERVIEW* – including psychometric testing. The material in Example 2, page would be an example of a **BRIEF SCREENING PSYCHOSOCIAL INTERVIEW**. Examples 3, 4 and 5 would be examples of **BRIEF SCREENING STANDARDIZED INSTRUMENTS**. (see pages to).

These styles range on a continuum with respect to the degree of structure imposed, from unstructured to highly structured.

The degree to which the interview is structured (successfully) depends upon the goals of the interview, the condition of the client, and the requirements of the agency's policy.

Although screening is an essential step in the assessment process, for the purposes of this program, we are going to focus on **BASIC COMPREHENSIVE PSYCHOSOCIAL ASSESSMENT**.

Module 2: INTERVIEW
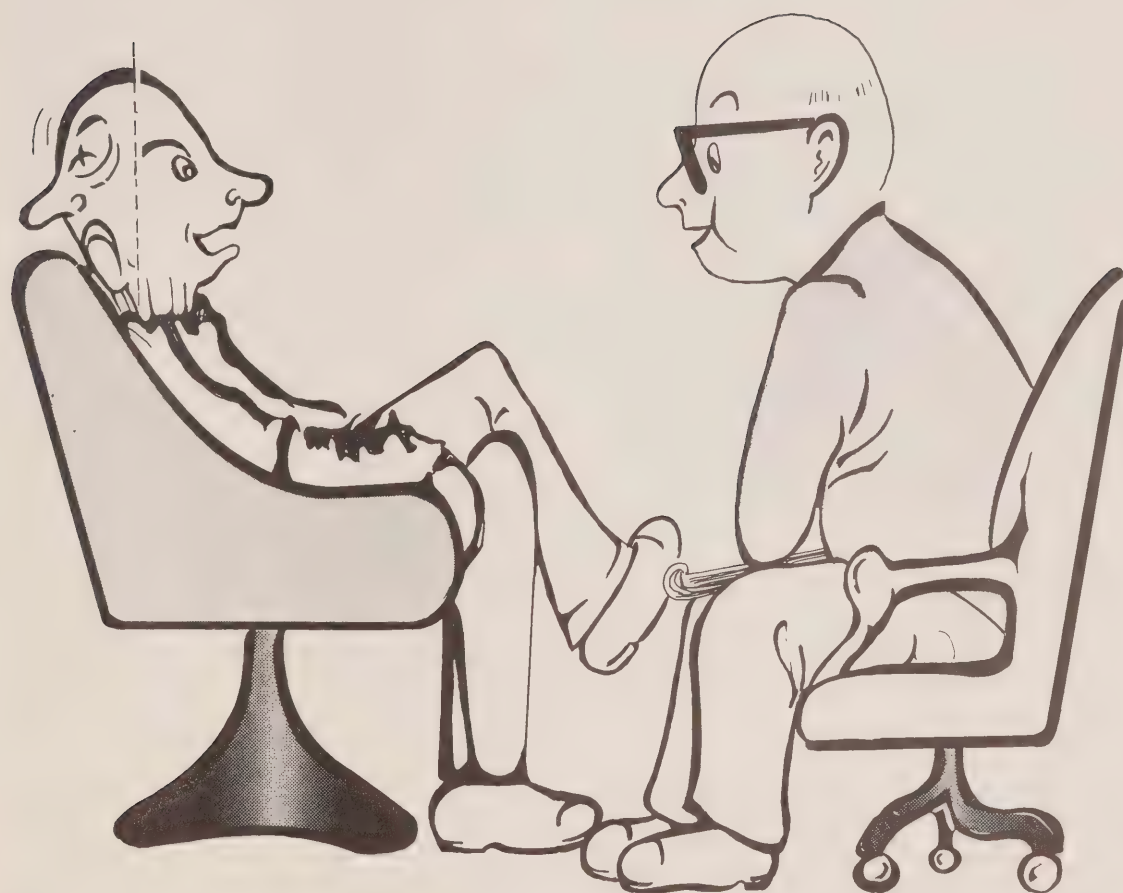
Module 2: INTERVIEW

BEGINNING THE INITIAL INTERVIEW

Introduction

It is quite possible that the destiny of the therapeutic relationship is cast during the first 10 minutes of the initial interview. All too frequently, clients fail to return for their "second" interview amidst therapist protestations of "lack of motivation". Indeed, some clients may have very little motivation; however, if they do show up for an initial interview it is indicative of some motivation (whether internally or externally generated). This Unit continues the development of the assessment process by outlining several practical issues to consider and procedures to follow in beginning an initial interview in order to optimize the chances that the client will benefit from the assessment process.

Key Issues to Consider in Beginning the Initial Interview

A. The Presenting Problem

The counsellor must first consider whether the client is in a state of crisis. A crisis may be defined loosely as a situation where the client is in a physical or emotional state of such an acute nature that he or she cannot muster the internal strength to cope with the problem, nor can he or she relate to their environment constructively until the problem is resolved. If such a state does exist, the interviewer must first deal with the issue at hand before attempting to undertake the comprehensive assessment.

Aside from the acute state of a crisis, there is a range of sub-acute states which must be considered in the light of their relevance to the assessment process. When a client presents for an initial interview, he carries with him some affective factors. For example, is he here of his own volition or is he being coerced to attend? Are there precipitating events which led to his decision to seek help at this time? Did he think of treatment on his own, or was he referred by someone else? All of these issues have a direct influence on the client and must be at least minimally acknowledged at the beginning of the initial interview. If, for example, the client is an involuntary court referral, or is being coerced by his employer to seek treatment, the counsellor must, at minimum, acknowledge the fact, empathize with the client's affective state, and either explore the issue initially or agree to do so at a later time with the consent of the client. With respect to the first 10-20 minutes of the initial interview, the presenting problem is most important for its effect on the client's affective state and how it influences the client's perspective of the treater and the treatment process.

B. The Client's Perspectives and Values

The client's perception of alcohol use, his attitude toward change, and perception of why he is in treatment will undoubtedly have an influence on the client at the time of conducting the interview. Issues in this area do not stand alone, as they are frequently synonymous with or closely bound to the presenting problem. An illustration of the symbiotic relationship between the client's values, attitudes, and perceptions and the presenting problem could look like this:

A male client appears for treatment having been pressured by his wife and family to seek help after his third impaired driving charge in two years. He personally doesn't believe that he has a drinking problem as he has always been a good provider. Furthermore, he doesn't think that a "real man" would ever admit to a young female counsellor that he has a "problem" anyway. He thinks that if there were any problems in his family, "that is where they should stay" – they shouldn't be talked about to strangers.

In this example, you can see that there are several problems which could have influence on the initial interview, and that the client's perspectives and values are indeed part of the presenting problem. What is important to beginning an initial interview is not only that the

counsellor take note of the client's values, attitudes, and perspectives, but, that the counsellor react in such a way as to be supportive of the client, but not necessarily of his views. This leads to the third category of issues – those relating to the counsellor.

C. The Counsellor's Perspectives and Values

There have been numerous articles and books written about counsellor characteristics and activities which facilitate communication and "engage" the client (Benjamin 1974). The counsellor's values and attitudes must allow him or her to respond sensitively to the client's presenting problems, including perspectives and values. The recognition of the client's presenting problems may, however, raise the issue of contraindications for the counsellor's or agency's involvement. An important facet of the assessment process includes a thorough understanding and recognition of your own capabilities and limits as a "treater". In addition, it is quite possible that another agency (such as a hospital) may be a more appropriate entry into a treatment system for some clients (for example, when a psychiatric disorder is suspected).

Two categories of contraindications are illustrated by the following two questions:

(a)   Am I the right person to be treating (or assessing) this client?

(b)   Given its mandate, is this the appropriate agency to be treating (assessing) this client?

The answers to these two questions will most definitely influence what will happen beyond the first 10 minutes of the interview. The decision as to whether or not to continue in treatment beyond the initial interview must be a joint decision between the client and counsellor. As part of the beginning of the initial interview, it is important that the counsellor (or interviewer) orient the client to both the "style" of the counsellor (i.e., how the counsellor usually works) and to the agency itself in a general sense. Frequently, clients do not understand what treatment is all about, nor do they understand how agencies function. Issues such as whether or not there is a charge, how long treatment lasts, can clients be seen in the evenings, how often clients are to come for sessions, and a multitude of other questions, if left unanswered, can interefere with the progress of the client in treatment.

The final, and possibly most potent, factor in the initial interview is the attitude of the counsellor/interviewer (see pages to). Just as the counsellor assesses the client, so too does the client assess the counsellor, the agency, and the treatment process. The attitudes, values, and practices of the counsellor must create an atmosphere in which issues can be explored in a manner conducive to the development of a professional client/counsellor relationship. It is important that the counsellor keep in mind the difference between a helping friend and a professional helper. When a friend counsels another friend, by virtue of the relationship, the process of meeting needs is a two-way street. That is, the helping friend's needs are being met by being a good (helping) friend. In a professional counselling relationship, the counsellor must not allow himself the luxury of meeting his own needs through the counselling process – the focus of the relationship must be on the needs of the client. This is particularly relevant to the beginning of the initial interview when the client is trying to decide whether or not you can help him.

CONTENT, PRINCIPLES, PROCEDURES AND TOOLS

Introduction

At this juncture, it is important to catch up on some additional material before moving into the actual body of the initial interview. To this point, we have examined levels of assessment, types of assessment, and important elements to consider in beginning an assessment interview. We will now consider four additional sets of material before we view the initial interview:

(a)   the principles under which assessment interviews should be conducted, i.e., how assessment "fits" into the treatment system;

(b) the major impact of alcohol abuse on the body;

(c) signs and symptoms of alcohol abuse;

(d) the content areas which a basic comprehensive assessment should cover.

The assessment process is part of the system of treatment that is available to clients. In some jurisdictions, the treatment system is very complicated with a multitude of resources, while in others, one person struggles to perform all of the functions of different components of a treatment system. In most circumstances it is assumed that there will be more than one individual involved in the social service network in a community. For this reason, we are taking a step back from the actual conduct of the interview, to put the assessment process into perspective in the entire treatment system. To do this we will examine the principles under which assessment takes place as part of a coordinated system. These concepts are introduced at this juncture as they have a direct influence on the conduct of the initial interview and subsequent treatment planning. There are four categories of principles relating to the assessment process.

A. *Principles Relating to the Assessment Process*

I Systems Principles

(a) Client/patient records should be afforded the same level of confidentiality as hospital records;

(b) assessment resources (if they are not also conducting treatment) have a responsibility for ensuring continuity of care for clients through linkage of the client to a (case manager/aftercare) resource, subject to agreement of the client;

(c) in order to be cost effective, assessment should be sequential and should progress from basic to comprehensive levels to specialized assessment (if the latter levels are warranted);

(d) it is important to establish ethical standards for assessment/treatment resources consistent with those of other health and social services and with recognition of those specifically embedded in law;

(e) there should be use of a common data set (or sets) so as to facilitate client monitoring and program evaluation on a broader geographic base, carried out with due regard for client confidentiality;

(f) systematic feedback on the appropriateness of referrals should be monitored and used to refine the assessment procedures and referral strategies when the assessment is conducted by someone other than the treater;

(g) there should be sufficient assessment/referral/treatment resources to allow easy access to the treatment system and to facilitate continuity of care;

(h) each assessment/referral/treatment resource should use standardized, reliable interview formats which are in keeping with the community's data collection capabilities. Assessment/referral/ treatment resources should make use of results of research into assessment/referral/treatment processes.

II Operating ("Functional") Principles

(a) Assessment implies mutual exploration of the problems experienced by a client in his/her life situation; an examination of alternative courses of action available to him/her, and a decision on intervention which takes into account the client's perception of his/her own particular needs, since treatment requires active client participation;

(b) the assessment function carries responsibility for action (intervention) and, therefore, assessment should not be divorced from a plan of intervention;

(c) appropriate referrals depend on a sound working knowledge of community resources, and the ability to utilize these resources effectively;

(d) assessment includes an analysis of the client's problems, with respect to both their nature and urgency, as well as the client's strengths. These problems and strengths must be viewed in the context of the client's environment and the potential of the environment to inhibit or facilitate change;

(e) subject to written release by the client, the assessment resource should provide to the referral agency a summary of the assessment findings and plan for intervention. The assessment resource should arrange to have the referral agency provide relevant information;

(f) in the operation of assessment/referral/treatment resources, local consensus and policy should be developed with respect to problems arising in the management of clients.

III   Training Principles

Training requirements for personnel conducting initial interviews include:

(a) Training in basic interviewing skills. These skills are needed to accurately perceive, understand, and respond to client/patient situations which are commonly encountered in assessment contacts;

(b) training in assessment process and procedures;

(c) development of a knowledge of resources which are available in the community, their characteristics, and their accessibility;

(d) training in establishing cooperative interagency working relationships;

(e) recognition of the need for continual updating of skills and knowledge.

IV   Community Development Principles

(a) Cooperative interagency working relationships must be established with a wide range of resources, beyond those normally associated with the specialized treatment of alcoholism or health care delivery;

(b) the assessment/referral/treatment resources must be recognized and accepted by the community as a desirable element of the community's helping resources which can facilitate more effective and efficient use of these resources for persons in the community who have alcohol and/or other drug-related problems;

(c) provisions should be made for the helping persons/resources of the community to share their observations and documentation concerning deficiencies in existing resources;

(d) in many communities some dependence-specific resources/services will not exist. Development of these resources/services or, more commonly, appropriate alternatives should become a community objective, incorporated where possible into existing structures or resources/services. (Addiction Research Foundation, 1982).

B.   *Life Area of A Basic Comprehensive Assessment*

We are now at the point of examining the "body" or content of the material, which, when combined with PRACTICAL DRUG CONCEPTS KNOWLEDGE and COUNSELLING/ COMMUNICATION SKILLS, results in the conduct of the initial interview. Two examples of

the material covered during the assessment process are included (see Examples 6 and 7, pages and). As an examination of the materials will indicate, although the format and styles may differ, the areas covered by the assessment are similar.

It must be noted that all of this material may not be covered in a single session. In some instances, it may be possible that all of the life areas may be explored within a single session, but in others, it may take three or four sessions. During the initial interview, however, the foundation for assessing the client is laid down and the process of assessment begun.

There are different approaches to using the assessment materials in this module ranging from a standardized approach, where the materials are brought into the interview and followed to the letter, through to the use of the materials as a guide during the interview and a checklist once the initial interview is completed. It is the opinion of the authors that the latter is often preferable and the materials of this Unit have been oriented to this approach. However, as noted earlier, the issue of structure is one which ranges on a continuum, depending on the interviewer's goals, client's condition, and policies imposed.

A final comment on the assessment process, in order to keep a healthy perspective on the initial assessment, must highlight the dynamic relationship between assessment and treatment. The initial assessment is the basis on which a treatment plan is constructed; however, assessment does not stop here. Ongoing assessment continues throughout treatment, allowing each progressive step the client makes to be fed back into the treatment process to modify the treatment plan. This dynamic relationship is struck in the initial interview when the interviewer begins the exploration of the life areas of the basic comprehensive assessment.